

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT.

(M)

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(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
971 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00963											
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park						c. LENGTH OF STAY IN tb 18 years					
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 52 Takoma Park						d. STREET ADDRESS 503 - Belford Place					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 503 Belford Place						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Bessie June Ashley						4. DATE OF DEATH January 31 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 8 1879		9. AGE (in years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Emerick						14. MOTHER'S MAIDEN NAME Caroline Lowry					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs Mabel A. Hauser, Prince Georges			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Debility 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of rectum DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF Feb 4 1961		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Mausoleum		22d. LOCATION (City, town, or country) (State) Minneapolis Minnesota	
23. FUNERAL DIRECTOR Arthur Walters						ADDRESS 254 Carroll St NW DC		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
								DATE FEB 2 '61			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

972

CERTIFICATE OF DEATH

00964

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb 22hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 66 Riverdale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hosp.				d. STREET ADDRESS 6101 Norman Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Girl Last Baldwin				4. DATE OF DEATH Month 1 Day 12 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 1, 1961		9. AGE (In years last birthday) yrs. 22 Min. 55	IF UNDER 1 YEAR Months 22 Days 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Timothy Baldwin				14. MOTHER'S MAIDEN NAME Mary Concepcion McKnew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT Mother		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.5 Atrial Fibrillation DUE TO (b) P rematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from January 11, 1961 to January 12, 1961 , that (I) (we) last saw the deceased alive on January 11, 1961 and that death occurred at 4:15am on the causes and on the date stated above.							
22a. SIGNATURE Stanley H. Steinberg				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-12-61	
22c. PHYSICIAN'S NAME (Type) Stanley H. Steinberg				22d. ADDRESS 8106 New Hampshire Ave. Sil Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 13, 1961		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons				ADDRESS Hyattsville Md.		25a. REC'D BY REGISTRAR DATE JAN 16 '61	
						25b. REGISTRAR'S SIGNATURE Arthur L. House	

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1. The first part of the report deals with the general situation in the country. It is a very interesting and informative study of the country's development during the last few years. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation. It is a very detailed study of the country's economy during the last few years. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's economy.

3. The third part of the report deals with the social situation. It is a very detailed study of the country's social conditions during the last few years. The author has done a great deal of research and has gathered a wealth of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's social conditions.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

973

CERTIFICATE OF DEATH

Reg. Dist. No. 00965

1. PLACE OF DEATH a. COUNTY Prince George Co MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write nearest town) Prince Laurel Md		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 01 Laurel	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Laurel General Hospital		d. STREET ADDRESS 1518 Main St	
3. NAME OF DECEASED (Type or print) Baldwin Wm		4. DATE OF DEATH January 24 1961	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 25 1882	
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Government Printing Wash DC	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME T. M. Baldwin		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Ethel A. Baldwin		Address 1518 Main St Laurel, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Lymphatic Leukemia (c) Diabetes mellitus, Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-24-1961 to 1-24-1961 that I last saw the deceased alive on 1-24-1961, and that death occurred at 7 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE IDOLO PIERANDREI M.D.			
PHYSICIAN'S NAME (Type) IDOLO PIERANDREI			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/61	
22c. NAME OF CEMETERY OR CREMATORY Ingle Hill Cemetery		22d. LOCATION (City, town, or county) (State) Laurel Md	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE FEB 1 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Brant			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

558

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]	
AGE [Faint handwritten age]		DATE OF BIRTH [Faint handwritten date]	
PLACE OF BIRTH [Faint handwritten place]		OCCUPATION [Faint handwritten occupation]	
CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
TIME OF DEATH [Faint handwritten time]		PLACE OF DEATH [Faint handwritten place]	
SIGNATURE OF PHYSICIAN [Faint handwritten signature]		SIGNATURE OF REGISTRAR [Faint handwritten signature]	
DATE [Faint handwritten date]		TIME [Faint handwritten time]	

This certificate is to be filed in the office of the Registrar of Births and Deaths, and a copy of it is to be sent to the office of the Health Officer, and to the office of the Coroner, if the death is sudden or violent, or if the cause of death is unknown.

768

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CERTIFICATE OF DEATH

66266

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, state RURAL and give nearest town) <u>Hillside</u>				c. LENGTH OF STAY IN 1b <u>20 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1107-57th Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>CATHERINE</u> Last <u>BELOCHER</u>				4. DATE DEATH Month <u>January</u> Day <u>24</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 13, 1902</u>	9. AGE (In years last birthday) <u>58</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Postal Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry O'Callaghan</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET HINKELBINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-22-0222</u>		17. INFORMANT Address <u>MRS SHARTZER-1107-57th Ave. Hillside W.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Cervix</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Generalized Metastases</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1959</u> , to <u>January 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>January 24, 1961</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>William Brainin</u>		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1/24/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>WM BRAININ</u>		22d. ADDRESS <u>6124 Central Ave Capitol Heights Md.</u>					
23a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>1/28/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MOUNT OLIVET Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>WASHINGTON, DC.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers Co-517-1195 SE. Wash</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
974 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00967

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for X-ray. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> c. LENGTH OF STAY IN <u>Brandywine</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hobson Clinic</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u> d. STREET ADDRESS <u>Box 116</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lloyd</u> First <u>Kenneth</u> Middle <u>Bell</u> Last			4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>1961</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Sept 27, 1960</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. AGE (in years last birthday) <u>3</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Leroy Bell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Deloris Jean</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Mary D. Bell</u> Address <u>same as #1</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, Broncho</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>491X</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>1-21-61</u>				
Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-24-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST Peters</u>			
22d. LOCATION (City, town, or country) (State) <u>WALDORE MD</u>		23. FUNERAL DIRECTOR ADDRESS <u>The Hunt Funeral Home, Waldore, Md</u>					
24a. REC'D BY REGISTRAR DATE <u>JAN 25 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>					

JOURNAL OF DOCUMENTATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

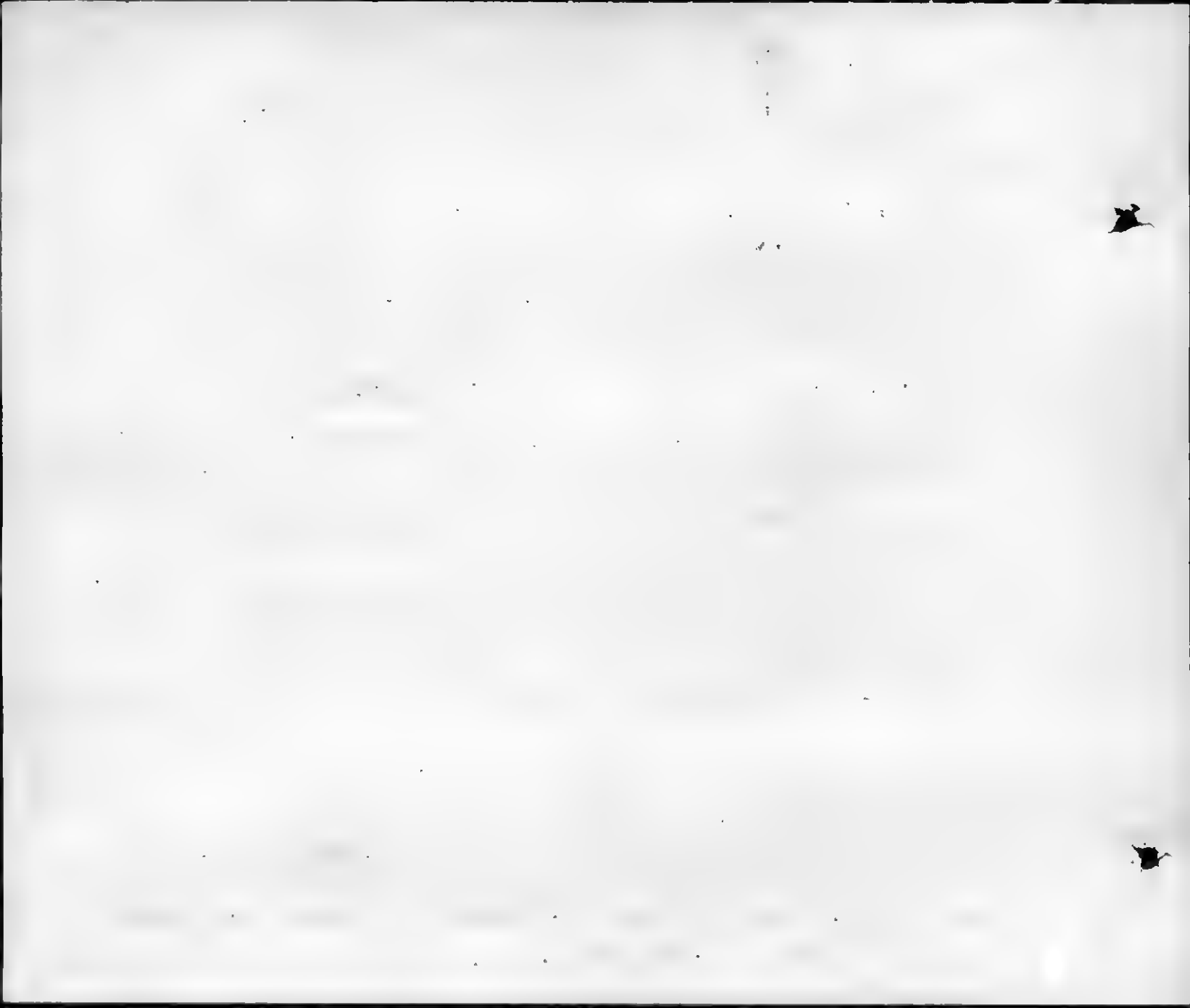
1 2

375

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

60908

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AIR FORCE BASE c. LENGTH OF STAY IN 1b LANDOVER HILLS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF Hosp, Andrews AFB, MD				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANDOVER HILLS d. STREET ADDRESS 4212 70th Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRED Middle BOENIT Last BOENIT				4. DATE OF DEATH Month JANUARY Day 23 Year 19 61			
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 23 July 1908	
9. AGE (In years last birthday) 52 yrs		10. IF UNDER 1 YEAR Months 3		11. IF UNDER 24 HRS Days 1		12. IF UNDER 24 HRS Hours 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AIRMAN		10b. KIND OF BUSINESS OR INDUSTRY US AIR FORCE		11. BIRTHPLACE (State or foreign country) CANADA		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME WILLIAM BOENIT				14. MOTHER'S MAIDEN NAME LAURA BOENIT HARRELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 1931-1959		17. INFORMANT Address WIFE (MRS FRANCES BOENIT) SAME AS ITEM #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thromboses of Abdominal Aorta and Coronary Arteries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUPLICATE DUPLICATE Undetermined Cause						INTERVAL BETWEEN ONSET AND DEATH 3 weeks UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY - Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 3 Jan 1961 to 23 Jan 1961 that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 23 Jan 1961 and that death occurred at 1255 PM , from the causes and on the date stated above.							
22a. SIGNATURE Charles S. Moon M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 23 Jan 61	
22c. PHYSICIAN'S NAME (Type) CHARLES S MOON, CAPT USAF (MC)				22d. ADDRESS USAF HOSP, ANDREWS AFB, WASH 25 DC			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1.27.1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home				25a. REC'D BY REGISTRAR 300.4th st N E.Wash.		25b. REGISTRAR'S SIGNATURE Walter S. Hearn	



CERTIFICATE OF DEATH

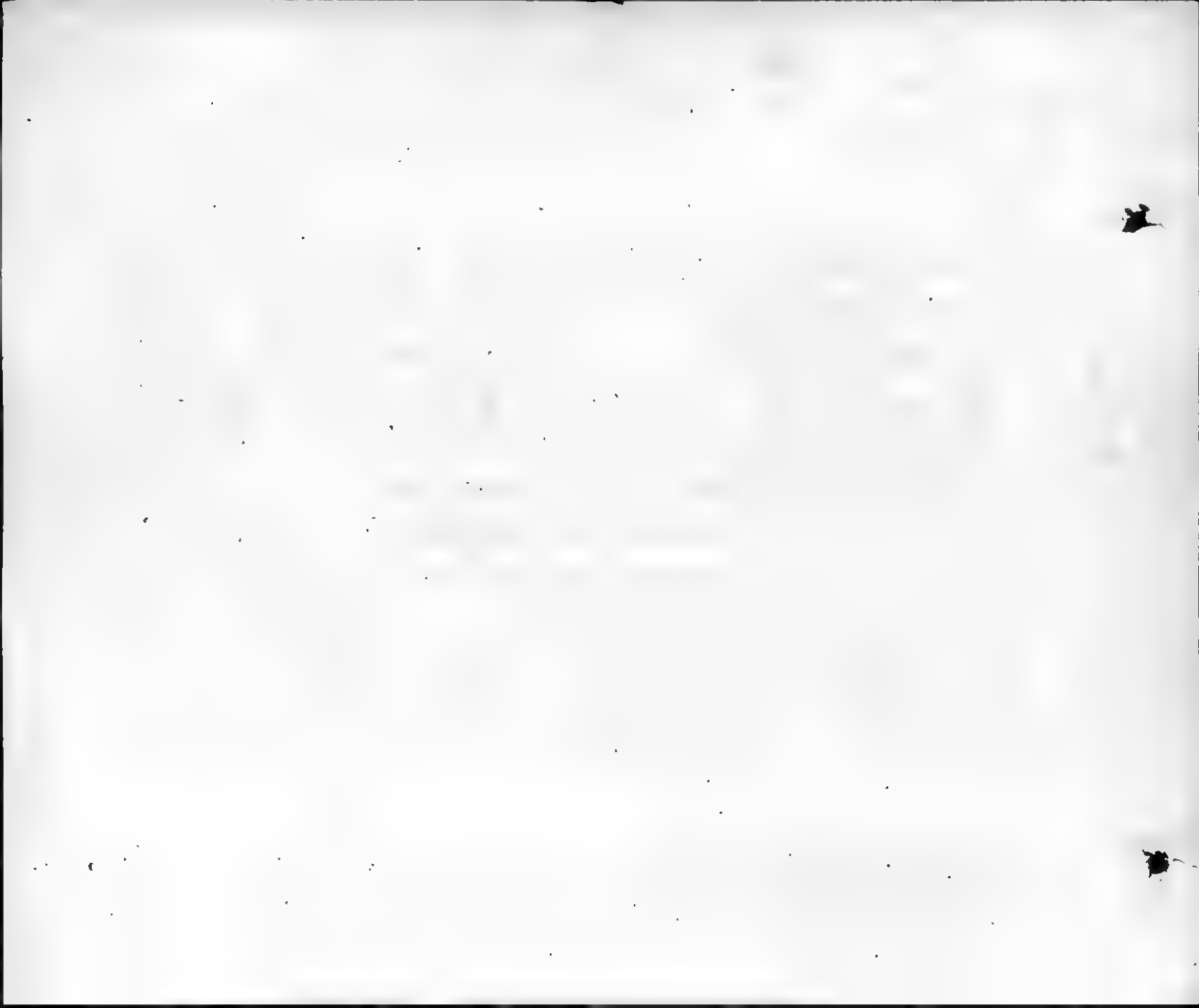
Reg. Dist. No.

66969

976

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital; give street address) OR INSTITUTION SOUTHERN MARYLAND HOSPITAL CENTER		e. STREET ADDRESS 5337 Middleton Lane	
3. NAME OF DECEASED (Type or print) First Middle Last CORA HARMER BISSETT		4. DATE OF DEATH Month Day Year JANUARY 8 1961	
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 20 1898
9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FREDERICK A HARMER		14. MOTHER'S MAIDEN NAME LILLIAN H. WARNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 577-10-6431	
17. INFORMANT DAUGHTER-IN-LAW		Address VIRGINIA KIDWELL CAMP SPRINGS MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CONGESTIVE HEART FAILURE 415.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) ACUTE MYOCARDIAL INFARCTION DUE TO (c) CORONARY ATHEROSCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 3 days unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from NOVEMBER 9, 1961 to JANUARY 8, 1961 , that I last saw the deceased alive on JANUARY 8TH , 1961, and that death occurred at 4:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE David N. Robb		ADDRESS (Street, city or town, state) 5116 Middleton Lane	
PHYSICIAN'S NAME (Type) DAVID N. ROBB		DATE SIGNED Washington 22, D.C. (Camp Springs Md)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-10-61	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Annapolis, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers + Co		24a. REC'D BY REGISTRAR 514-17th ST	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank		DATE JAN 12 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

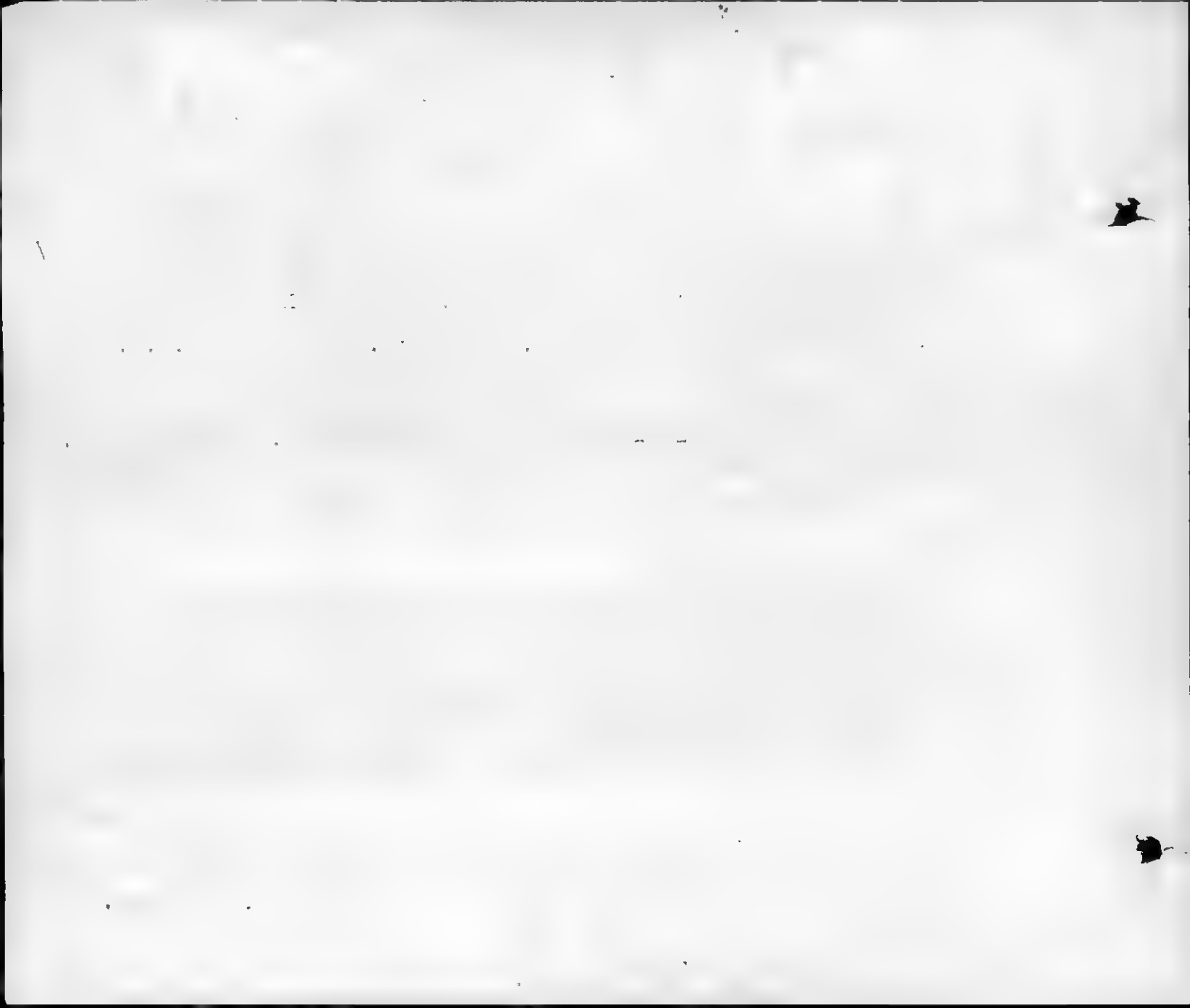
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

977

66970

1. PLACE OF DEATH a. COUNTY <u>Tr Geo</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Garnett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bellefonte, Md</u>		c. LENGTH OF STAY IN 1b <u>---</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1221 Dorset Lane</u>		d. STREET ADDRESS <u>11x</u>	
3. NAME OF DECEASED (Type or print) First <u>RAYMOND</u> Middle <u>E</u> Last <u>BITTINGER</u>		4. DATE OF DEATH <u>JAN 14</u> 19 <u>61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1889</u> <u>June 17, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter-Cabinet Maker, Self Empl.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Perry Bittinger</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ellen Speicher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-01-8319</u>	
17. INFORMANT <u>Delbert Bittinger</u>		Address <u>Mt. Lake Park, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 1421 DUE TO <u>Arterio Sclerotic Heart Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>30</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1-5</u> 19 <u>61</u> to <u>1-14</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-14</u> 19 <u>61</u> , and that death occurred at <u>1:30</u> PM, from the causes and on the date stated above			
22a. SIGNATURE <u>W.C. Etienne</u>		22b. DATE SIGNED <u>1-14-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.C. ETIENNE</u>		22d. ADDRESS <u>College Park, Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/17/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Oakland, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leighton Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 19 '61</u>	
ADDRESS <u>Oakland, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Evans</u>	

Leighton Funeral Home Oakland, Md.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

978

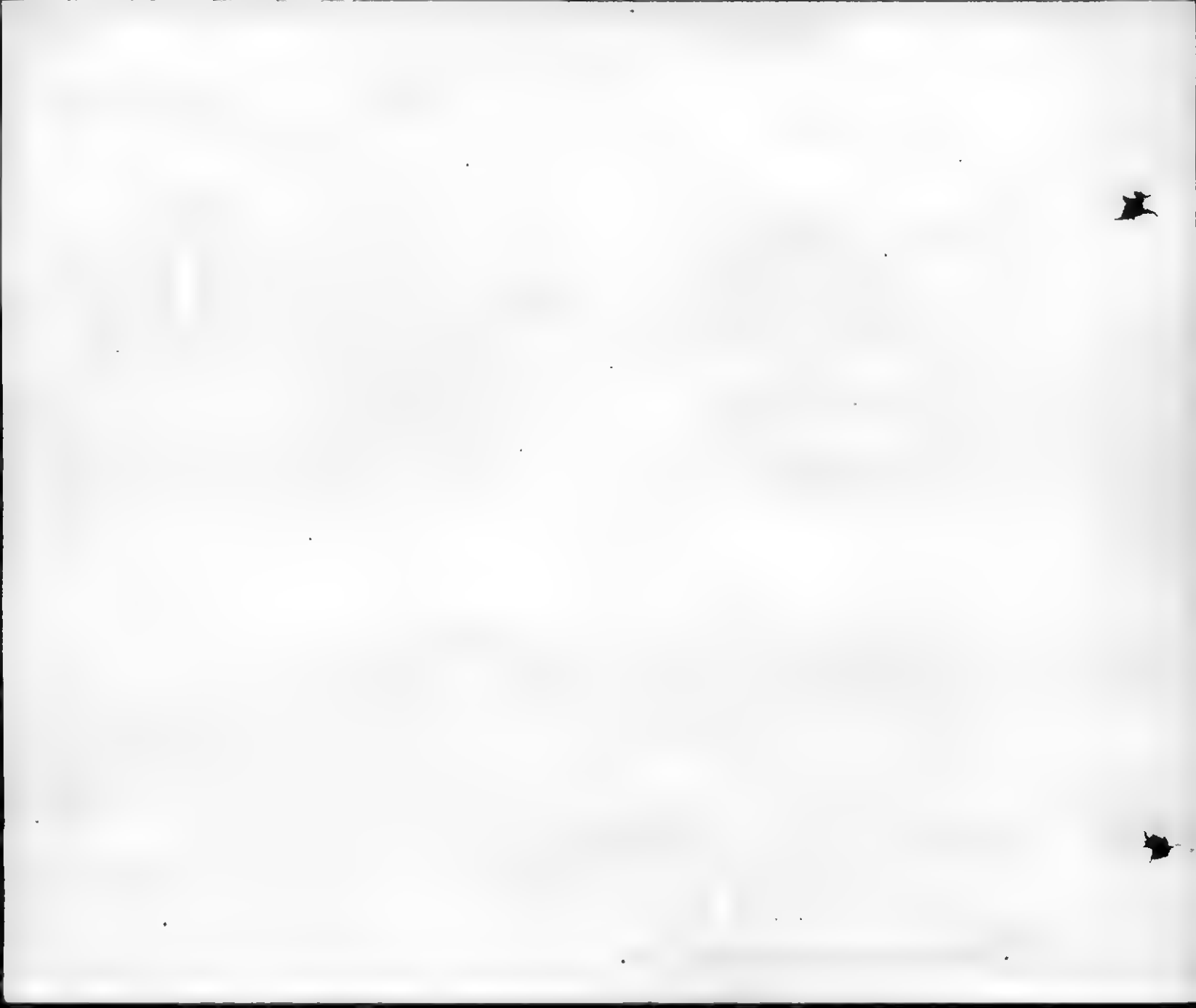
CERTIFICATE OF DEATH

00971

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Rainier,				c. LENGTH OF STAY IN 1b 25 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3711 Perry Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MR RAY Bollinger				4. DATE OF DEATH Month Day Year Jan 30 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 10, 1890	
9. AGE (In years lost birthday) 70 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William H. Bollinger				14. MOTHER'S MAIDEN NAME Stella Harbaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -----		INFORMANT Address Mrs. Nora R. Bollinger Same as #2 (Wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 410.0 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH 3 hrs 2 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/4 , 19 58 , to 1/30 , 19 61 , that I last saw the deceased alive on 1/30 , 19 61 , and that death occurred at 12:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 3503 Perry St 1/30/61 ACTUAL SIGNATURE Norman Donat Bameau M.D. PHYSICIAN'S NAME (Type) NORMAN DONAT BAMEAU MT RAINIER MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb 3, 1961		22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Md.				24a. REC'D BY REGISTRAR DATE FEB 2 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kneal	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

979

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

60972

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

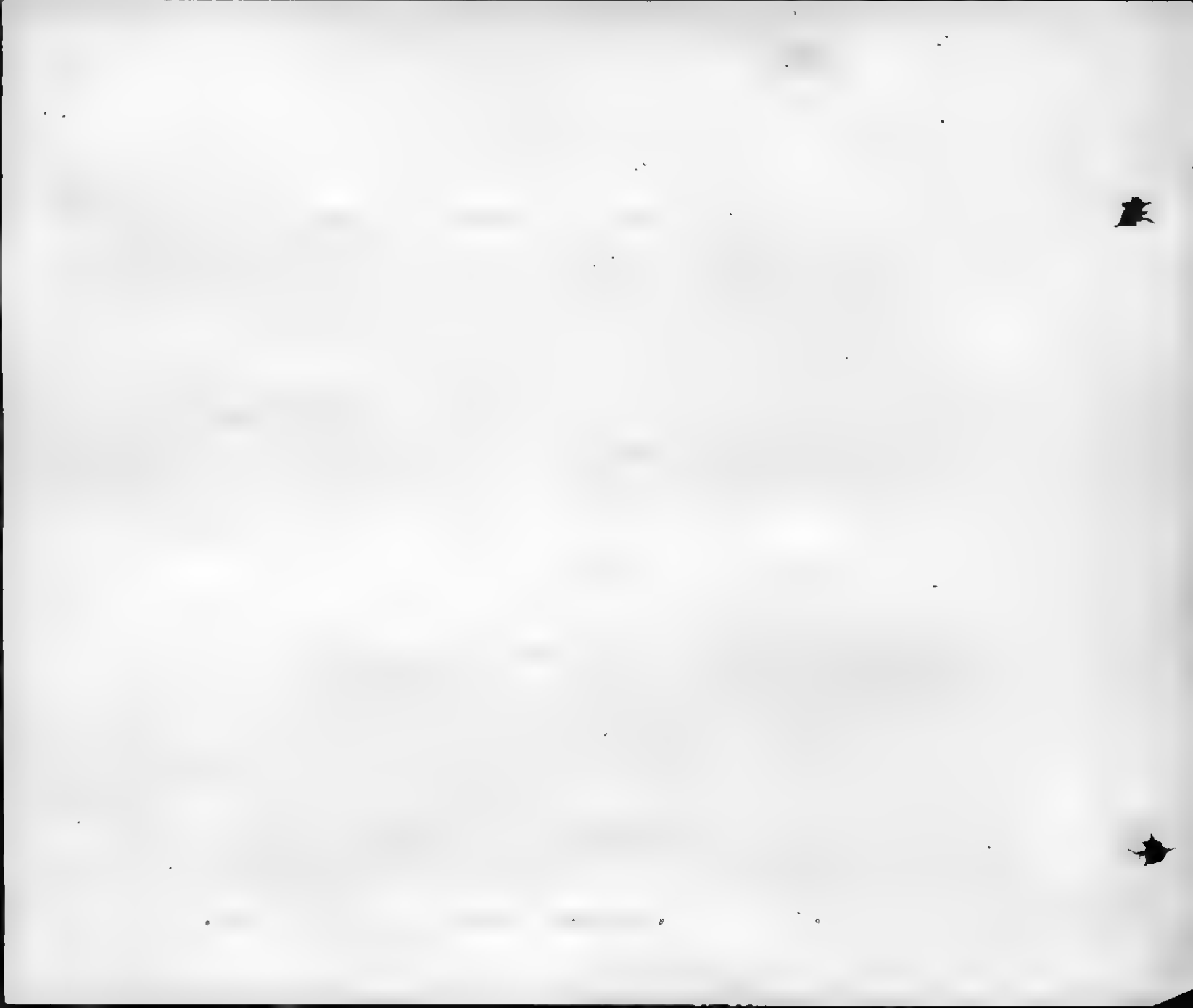
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		c. LENGTH OF STAY IN 1b <u>10</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>		d. STREET ADDRESS <u>1 Fletcher's Road and Rt 381</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wooded area</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Edith</u> Last <u>Booth</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 30, 1928</u>	
9. AGE (In years last birthday) <u>32</u> yrs.		10. UNDER 1 YEAR Months <u>3</u> Days <u>2</u>		11. IF UNDER 24 HRS Hours <u>5</u> M. <u>11</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Frank Stewart</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Watson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>Joseph Louis Booth, Seniors #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage and Shock</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gun shot wound of head</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY (Do not contributing) CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>shot self in the head with a 38 Cal Rem-um</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>1-5</u> p. m. <u>1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Wooded area</u>		20f. CITY or town (County) (State) <u>Brandywine P.G. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1-5-61</u>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Peters</u>		22d. LOCATION (City, town, or county) (State) <u>Waldorf Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. ...</u>	



1
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAYLAND
980
CERTIFICATE OF DEATH
60973

1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> <u>MARYLAND</u>				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN, lb <u>5 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>USAF Hospital ANDREWS</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1600 Pennsylvania Ave. N.E.</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>MATTHEW</u> <u>AM</u> <u>BOTTARI</u>				4. DATE OF DEATH Month Day Year <u>JAN</u> <u>10</u> <u>1961</u>			
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>CHI</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 2, 1884</u>	9 AGE (In years last birthday) yrs <u>71</u>	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS. Months Days Hours Min	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - DRISMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>			
11. BIRTHPLACE (State or foreign country) <u>MISSISSIPPI</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13 FATHER'S NAME <u>CESAR</u>				14. MOTHER'S MAIDEN NAME <u>GIOVANNA MARTELLA</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16 SOCIAL SECURITY NO <u>556-07-5043</u>			
17 INFORMANT <u>SON - M. L. BOTTARI</u>				Address <u>6212 BOTTINGHAM DRIVE WASHINGTON DC</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.3</u> DUE TO <u>Acute Respiratory Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma - Sigmoid</u> DUE TO <u>Intestine</u> (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>24 Hrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) _____							19 WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21 I certify that (H) (this hospital) attended the deceased from <u>19 Dec</u> <u>1960</u> to <u>10 Jan</u> <u>1961</u> that (H) (we) last saw the deceased alive on <u>10 Jan</u> <u>1961</u> , and that death occurred at <u>12M</u> , from the causes and on the date stated above							
22a SIGNATURE <u>Charles B. Mahon</u>				22b ADDRESS <u>USAF HOSPITAL ANDREWS, AAFB, WASH25, DC</u>			
22c PHYSICIAN'S NAME (Type) <u>CHARLES B MAHON</u>				22d ADDRESS <u>USAF HOSPITAL ANDREWS, AAFB, WASH25, DC</u>			
23a BURIAL, CREMATION, REMOVA. (Specify) <u>Burial</u>				23b DATE THEREOF <u>Jan. 13 1961</u>			
23c NAME OF CEMETERY OR CREMATORY <u>St. Raymonds Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Brooklyn N.Y.</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Frank Della Noce</u>				25a REC'D BY REGISTRAR <u>13100X</u> DATE <u>JAN 12 '61</u>			
25b REG STRAR 5 SIGNATURE <u>Charles B. Mahon</u>				25c REG STRAR 5 SIGNATURE <u>Charles B. Mahon</u>			

BALTIMORE MD.



66974

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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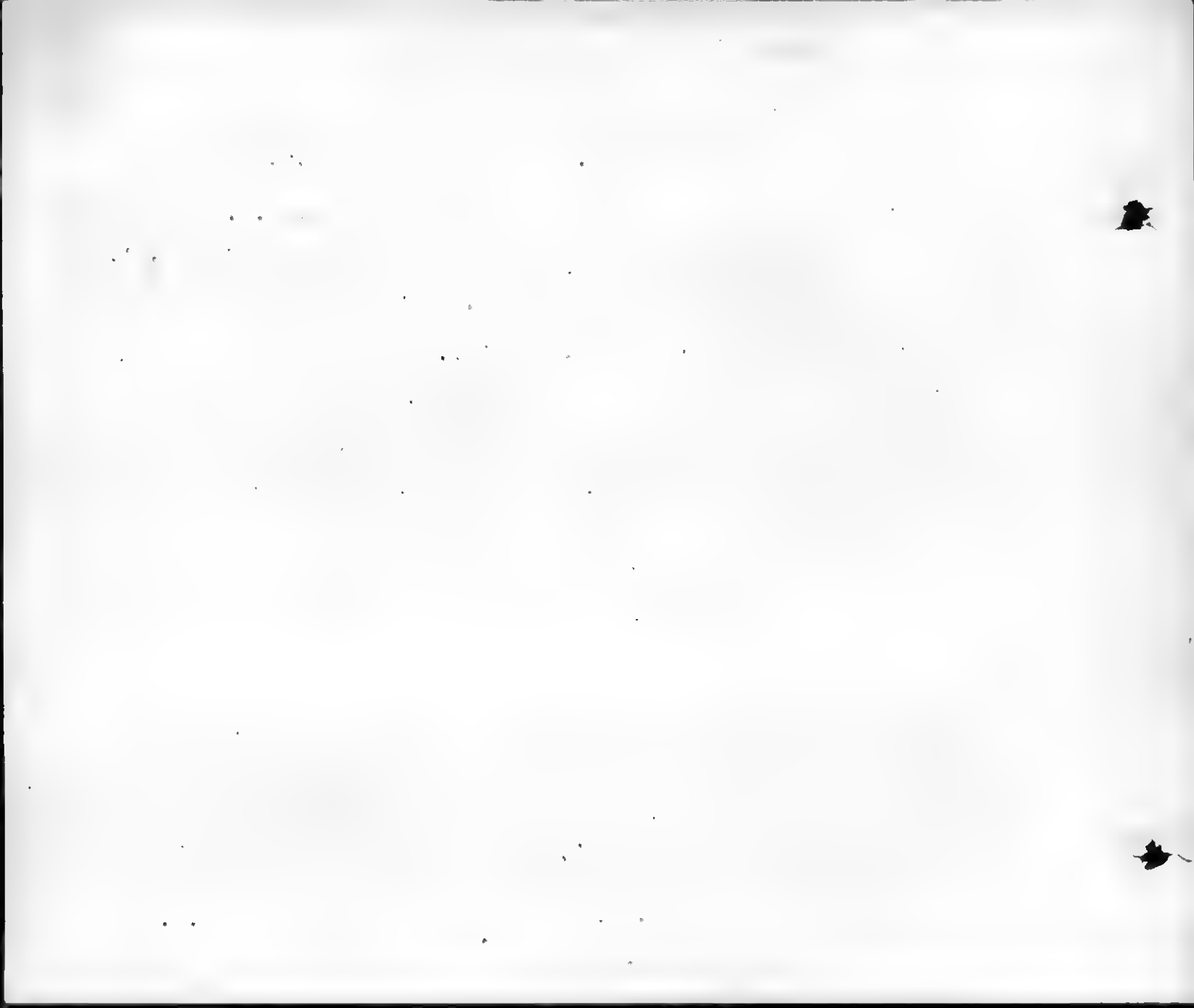
CERTIFICATE OF DEATH

Reg. Dist. No.

00975

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE -- b. COUNTY --	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum		c. LENGTH OF STAY IN 1b 6 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARROLL MANOR		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 472	
3. NAME OF DECEASED (Type or print) First MARGARET Middle R Last BREEN		4. DATE OF DEATH Month JANUARY 12, 1961 Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1868
9. AGE (In years last birthday) yrs 92		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Clerk		10b. KIND OF BUSINESS OR INDUSTRY Kann's Dept. Str. D.C.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael Breen		14. MOTHER'S MAIDEN NAME Bridget Crowley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mary Davis Crouch #2d above		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Myocardial Infarction DUE TO (b) Coronary occlusion DUE TO (c) Gen Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severity INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 13, 1961, to Jan 12, 1961, that I last saw the deceased alive on Jan 6, 1961, and that death occurred at 11:00 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5601 - 421 NW Wash DC DATE SIGNED			
ACTUAL SIGNATURE F. X. COURTNEY M.D.		PHYSICIAN'S NAME (Type) F. X. COURTNEY M.D.	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 16 Jan 1961	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE JAMES T. RYAN, Inc. 317 Pa. Ave., SE		24. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Curtis S. Knead	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

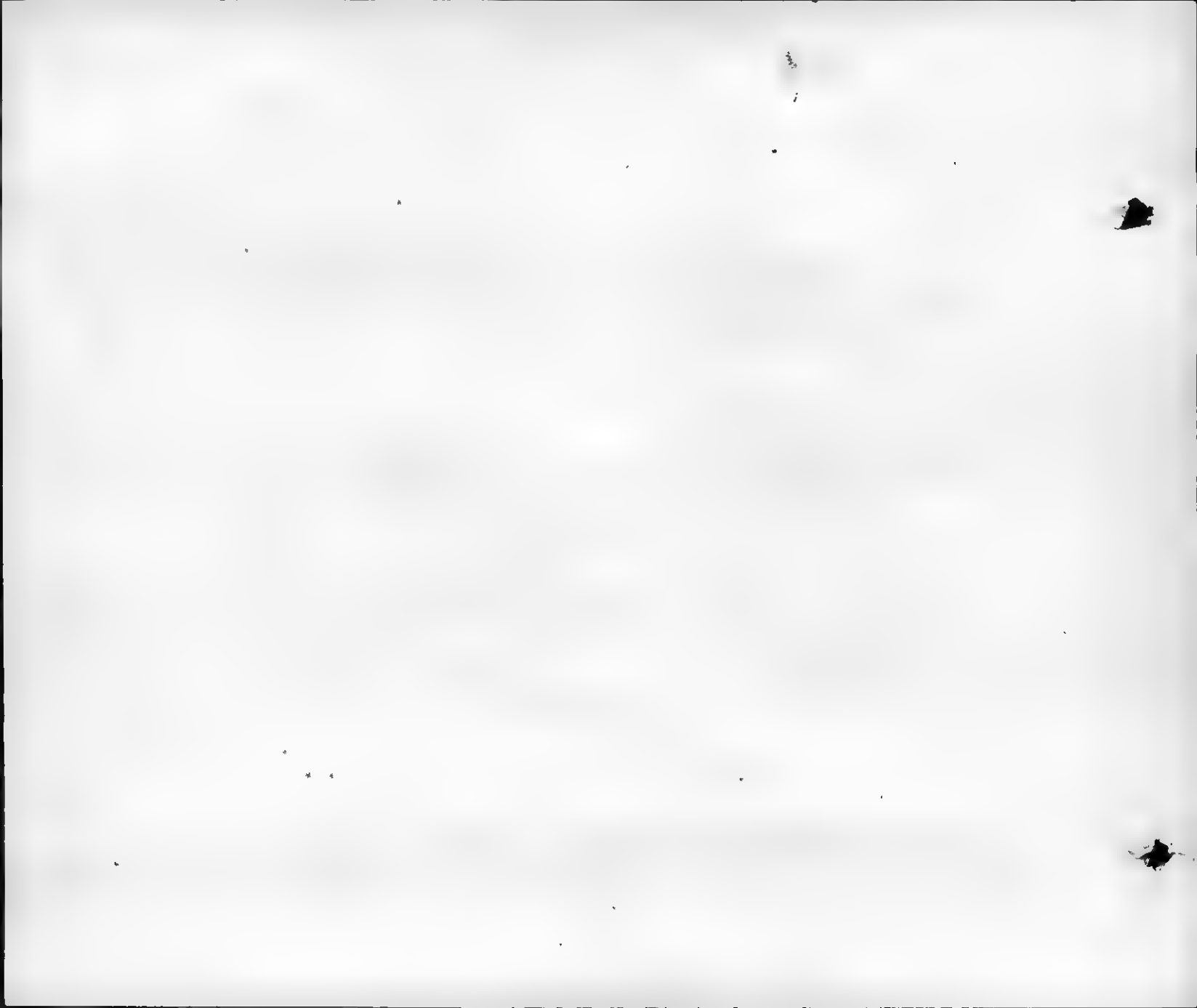
984

CERTIFICATE OF DEATH

Item 1 (Baltimore) 2-24-61 et

60977

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN 1b 1 Day		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital			d. STREET ADDRESS 7263 L St.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Pearl Middle Last Brown			4. DATE OF DEATH Month Jan. Day 25 Year 61		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 12 1887		9. AGE (In years last birthday) yrs 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ga.	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Starling Jackson			14. MOTHER'S MAIDEN NAME Malinda Jackson		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Nettie E. Davis Address 7263 L St. (Daughter)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis Heart Disease 450 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Malnutrition (c) Severe Dehydration					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 24 1961 to Jan. 24 1961 , that (I) (we) last saw the deceased alive on Jan. 25 1961 , and that death occurred at 10:25 A.M. from the causes and on the date stated above					
22a. SIGNATURE Wardlaw Kelley		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Wardlaw Kelley		22d. ADDRESS 6129-41st Ave. Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) 1-30-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Lincoln Mem.	
				23d. LOCATION (City or town, or county) (State) Suitland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE H.S. Washington			25a. REC'D BY REGISTRAR JAN 30 '61		
ADDRESS 4925 Pierre Ave NE			25b. REGISTRAR'S SIGNATURE Arthur S. Kramer		



CERTIFICATE OF DEATH

Reg. Dist. No.

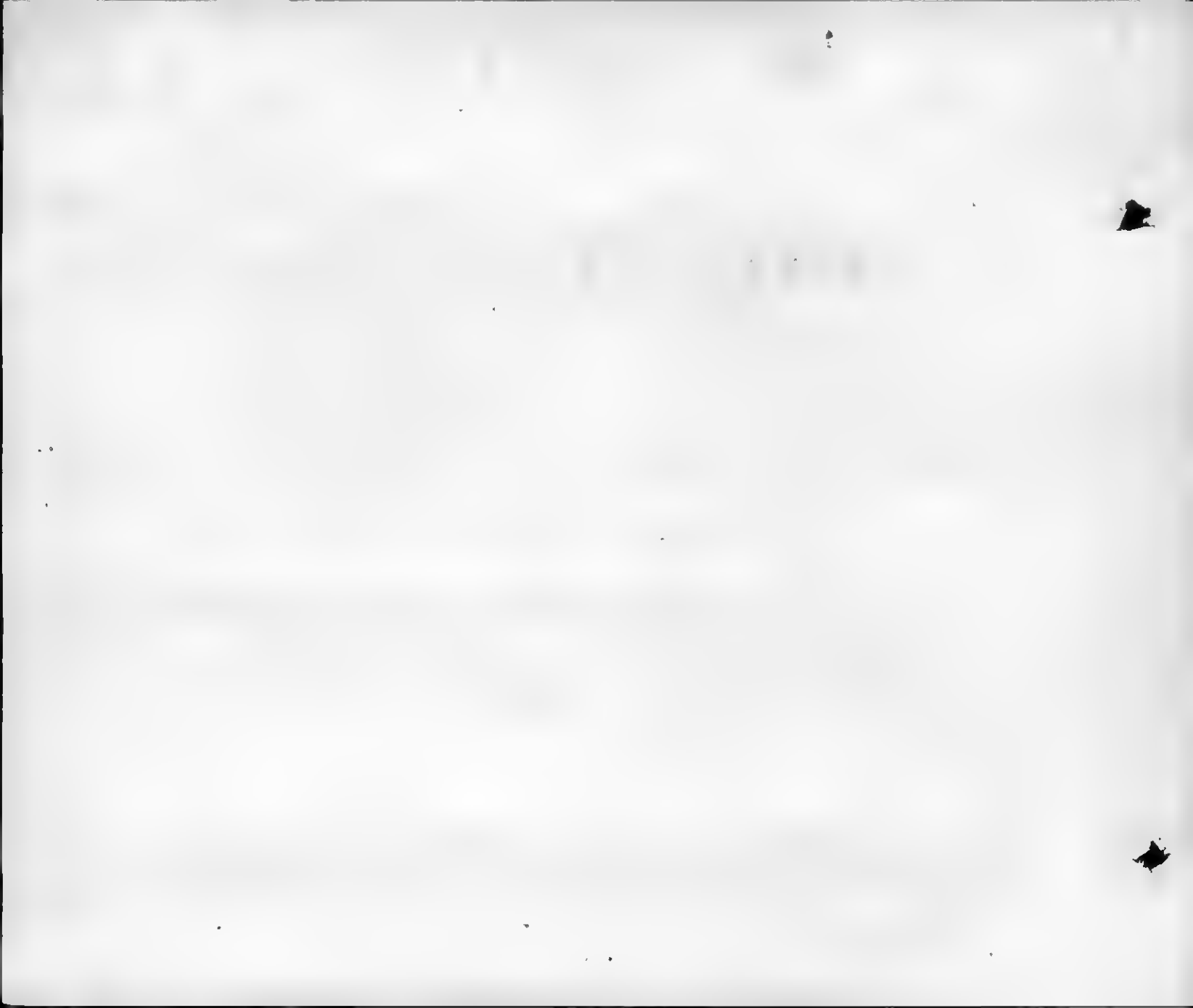
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985

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District Heights		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X District Heights	
c. LENGTH OF STAY IN 1b 13 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7406 Harwood Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rosa First ANN Middle BROWN Last		4. DATE OF DEATH Month JAN. Day 27 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 27th, 1872
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Josiah Edyburn		14. MOTHER'S MAIDEN NAME Mary Ann Sharp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Daisy W. Cole, 7406 Harwood Rd. District Hgts., Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last, (c) Cerebral Vascular Accident Arteriosclerotic Heart disease		INTERVAL BETWEEN ONSET AND DEATH 16 days 3 mo's Long standing	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized debility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-26-1960 to 1-27-1961 that I last saw the deceased alive on 1-11-1961 and that death occurred at 1:13 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 7200 MARLBORO PIKE DATE SIGNED 1-27-61 ACTUAL SIGNATURE W.B. Sheer M.D. W.A.S.H. 28, D.C. PHYSICIAN'S NAME (Type) WALTER B. SHEER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/2/1961	22c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery	22d. LOCATION (City, town, or county) (State) Muskogee, Okla.
23. FUNERAL DIRECTOR'S SIGNATURE W.A. Chambers Company, 517--11th St. S.E. Wash. DC		24a. REC'D BY REGISTRAR DATE JAN 31 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

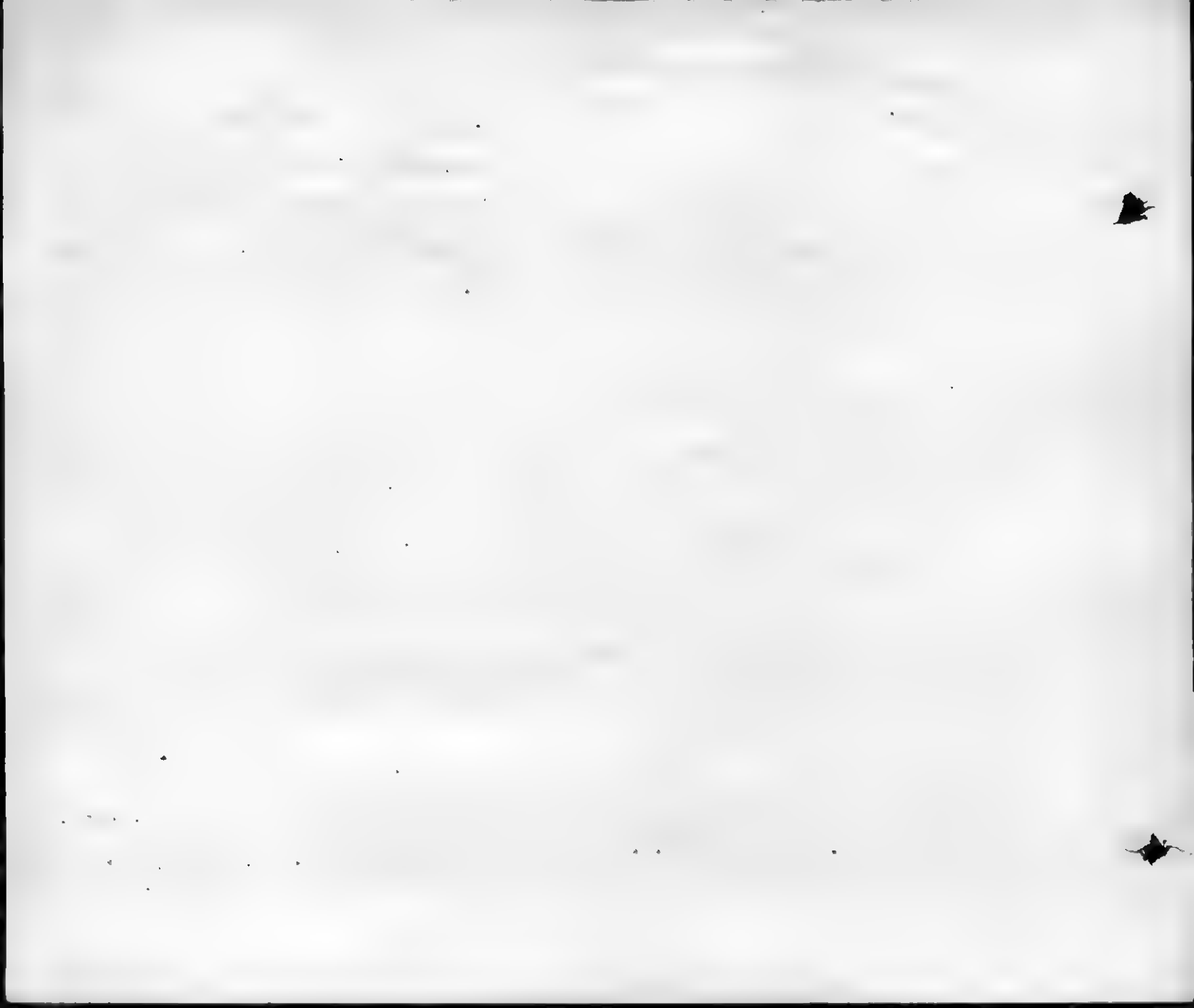
986

CERTIFICATE OF DEATH

Item 14 - 1-14-61 - 1-21-61

00970

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carrollton			
c. LENGTH OF STAY IN lb 3 Hr				d. STREET ADDRESS 5924 84th Place			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clarence		First H Middle Burgess		Last Burgess		4. DATE OF DEATH Month Jan Day 23 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1900	9. AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR Months 60 Days 60 Hours 60 Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE CONSTRUCTION		10b. KIND OF BUSINESS OR INDUSTRY CITY OF CHEVERLY, MD		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CLARENCE H. BURGESS				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO NO		17. INFORMANT MRS BARBARA J. COULTER, SAME AS #2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Cardiac Tamponade DUE TO Occlusion of left coronary Artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Arteriosclerotic H.T. Disease DUE TO Coronary Arteriosclerotic H.T. Disease DUE TO Coronary Arteriosclerotic H.T. Disease						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-14-61 to 1-21-61 that (I) (we) last saw the deceased alive on 1-21-61 1961, and that death occurred at 8:25A from the causes and on the date stated above							
22a. SIGNATURE Albert Roth				22b. DATE SIGNED 1-23-61		22c. PHYSICIAN'S NAME (Type) Dr. Albert Roth M.D.	
22d. ADDRESS 5510 Madison St., Riverdale, Md.				22e. ADDRESS			
23a. BURIAL, CREMATON, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN-26-61		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM		23d. LOCATION (City, town or county) (State) BLADENSBURG, MD	
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Riverdale Md				25a. REC'D BY REGISTRAR JAN-26-61		25b. REGISTRAR'S SIGNATURE Charles E. Riverdale	



CERTIFICATE OF DEATH

Reg. Dist. No.

00881

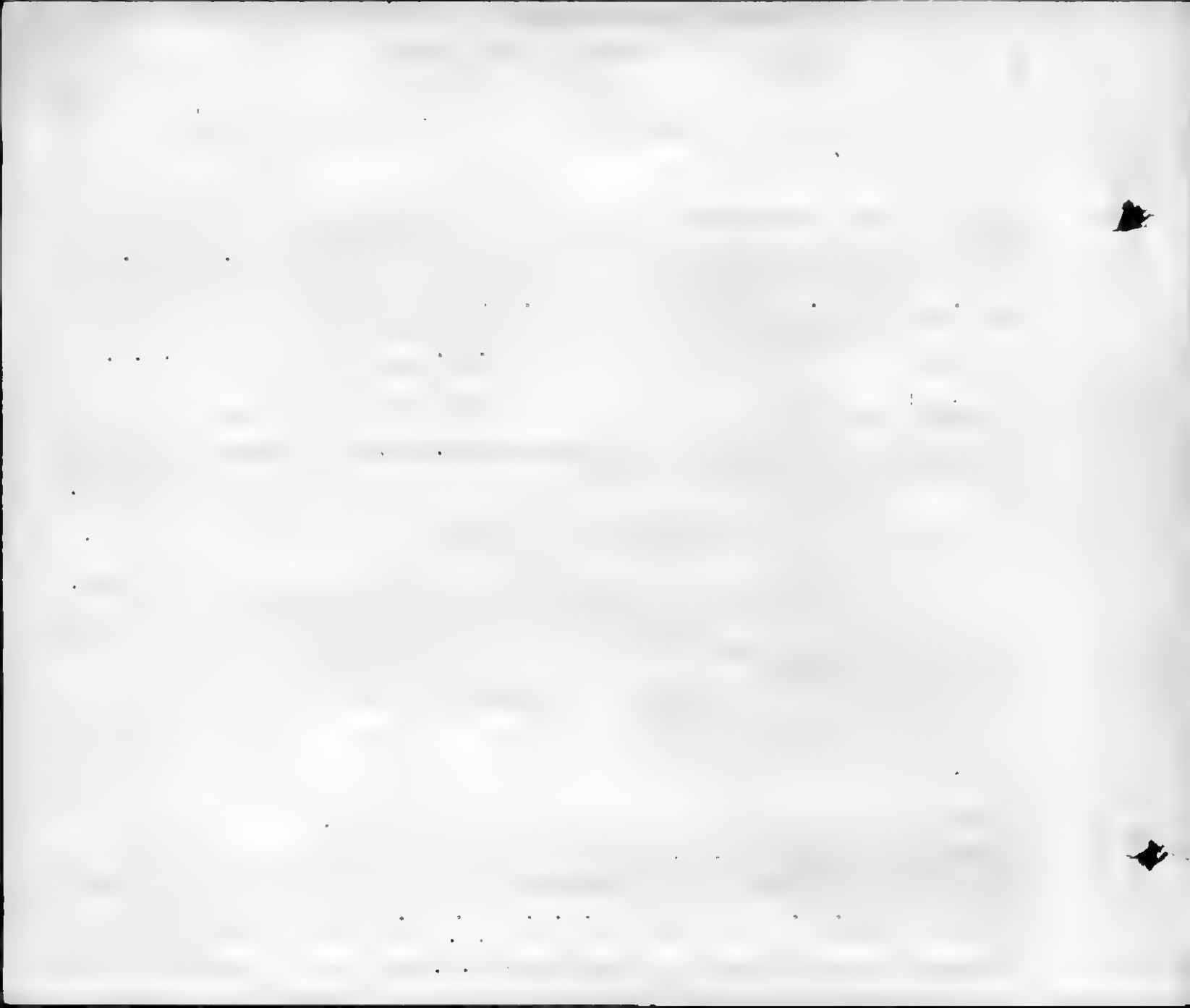
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1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHAPHILL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHAPHILL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 8700 LIVINGSTON RD.			
3. NAME OF DECEASED (Type or print) EVELYN BUTLER				4. DATE OF DEATH Month 1. Day 25. Year 1961			
5. SEX F.	6. COLOR OR RACE C.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7.13.09		9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. J.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM NEWMAN				14. MOTHER'S MAIDEN NAME ANNIE SAMPSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT WILLIAM E. BUTLER (SEE # 2 B)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTEIOSCLEROSIS, GENERAL DUE TO (c) HYPERTENSIVE CARDIAC DISEASE						INTERVAL BETWEEN ONSET AND DEATH 12 HRS. 6 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1, ANEURYSM OF ASCENDING AORTA, 2, AORTIC INSUFFICIENCY							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from July 20, 1956 , to January 25, 1961 , that I last saw the deceased alive on January 25, 1961 , and that death occurred at 11:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Accokeek, MD.							
ACTUAL SIGNATURE PAUL CHEN, M. D.				M.D. ACCOCBEEK, MD.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1.30.61		22c. NAME OF CEMETERY OR CREMATORY SHILOH A.M.E. MET. CH.		22d. LOCATION (City, town, or county) (State) NEWBURG, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. H. Smith				ADDRESS 1820 9TH, N.W. WASHINGTON, D.C.		24a. REC'D BY REGISTRAR DATE JAN 27 '61	
				24b. REGISTRAR'S SIGNATURE Robert L. H. Smith			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

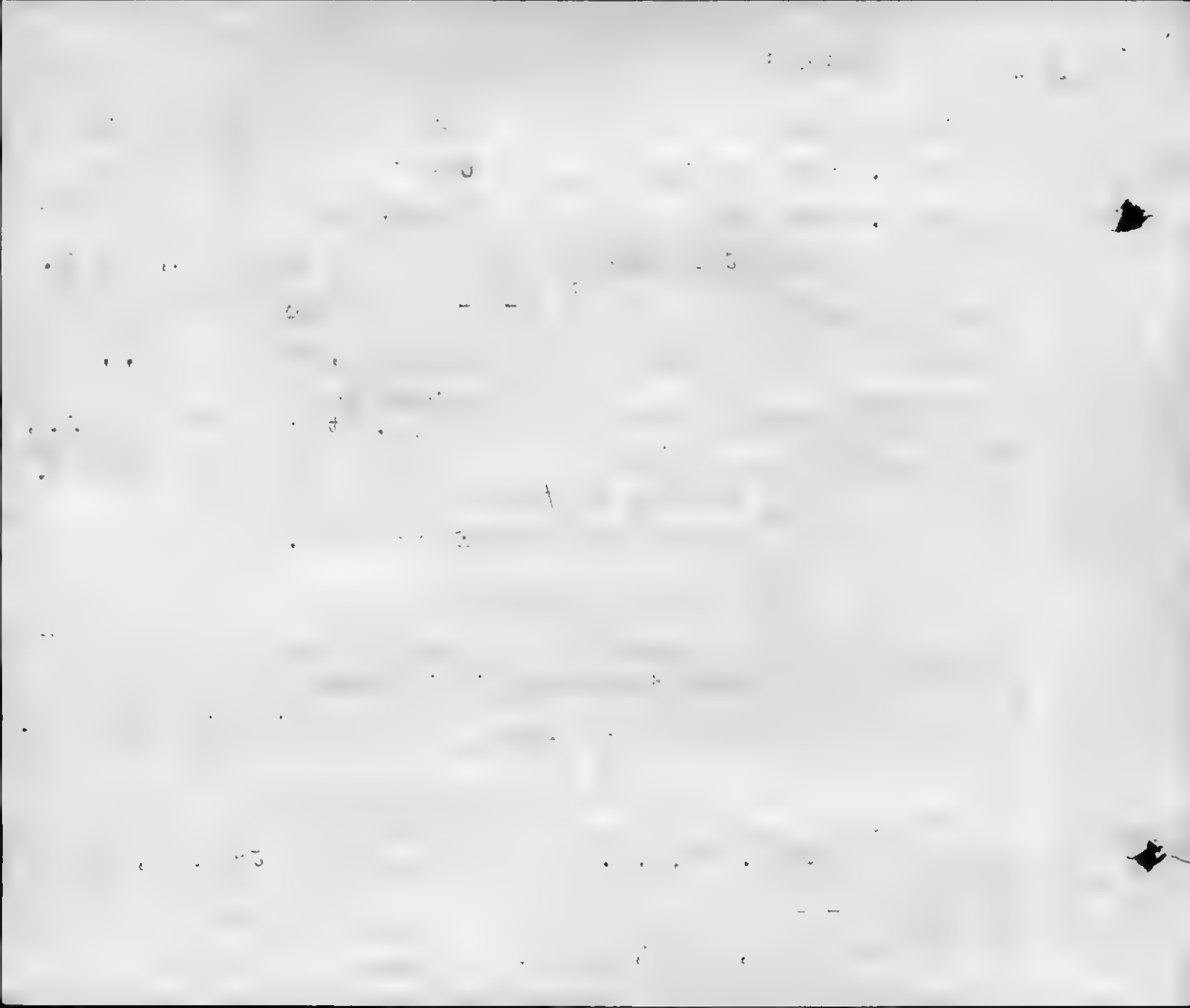


1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

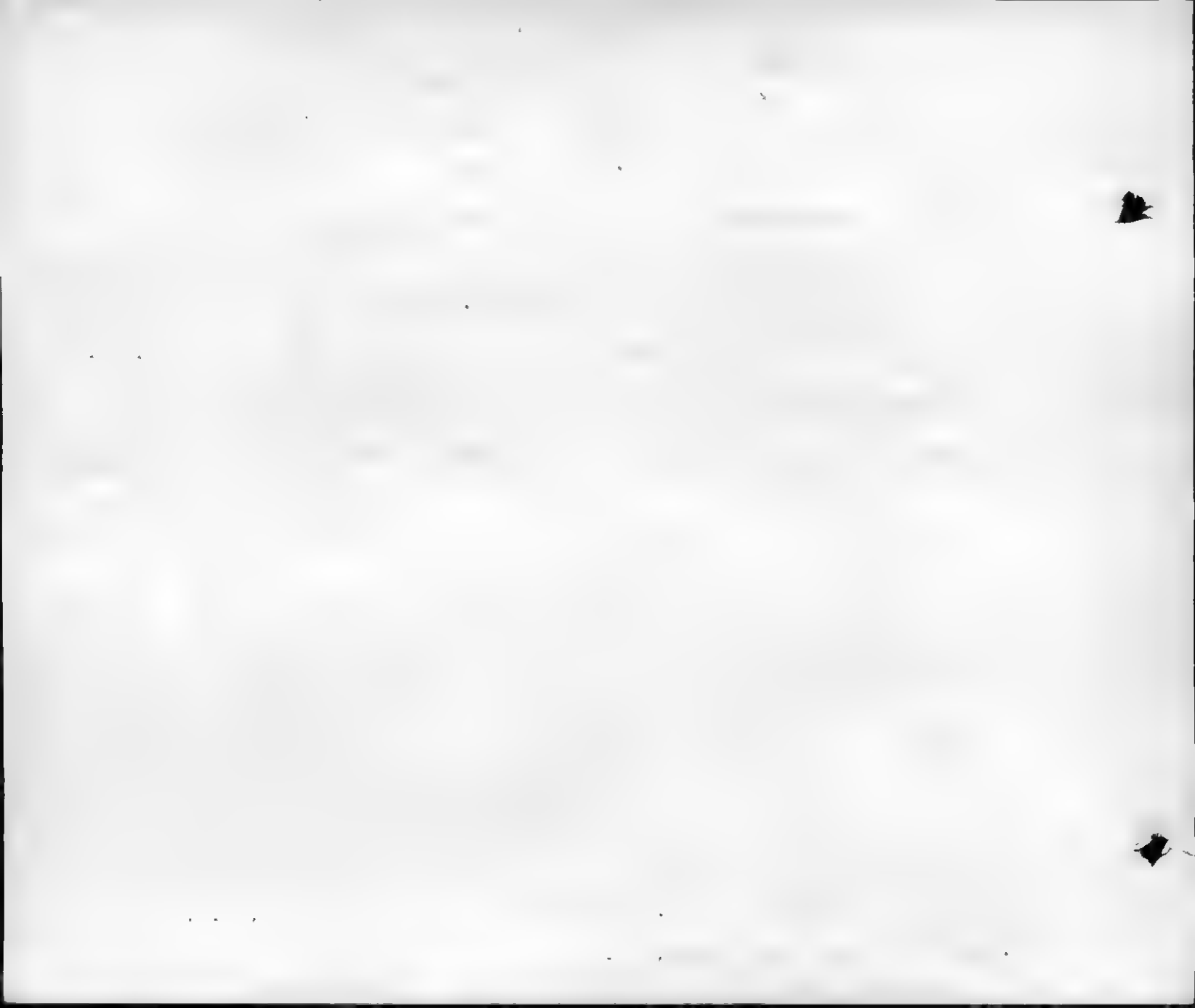
MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
988 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
00980											
1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6013 St. Barnabas Oxen Hill c. LENGTH OF STAY IN 1b 6013 St. Barnabas Road d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Res. since before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oxen Hill d. STREET ADDRESS 6013 St. Barnabas Road							
3. NAME OF MELZIE JOHN BUTLER (Type or print)				4. DATE OF DEATH January 7, 1961				5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3 - 4 - 1912		9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY General				11. BIRTHPLACE (State or foreign country) Maryland, Waldorf		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Butler				14. MOTHER'S MAIDEN NAME Georgianna Brown							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown				16. SOCIAL SECURITY NO. Unknown				17. INFORMANT Mary C. Butler PRINCE GEORGE COUNTY POLICE DEPT. WASH. DC.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage and Shock DUE TO (b) Gunshot wound right shoulder and chest. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a) INTERVAL BETWEEN ONSET AND DEATH 10.											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot during an altercation in his home							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1/7/ 1961 p.m. 1/7/ 1961				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Oxen Hill Prince Georges Cty.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1-14-61		22c. NAME OF CEMETERY OR CREMATORY Zion Wesley		22d. LOCATION (City, town, or country) (State) Waldorf, Maryland			
23. FUNERAL DIRECTOR THE HUNTT FUNERAL HOME, WALDORF, MARYLAND.						24a. REC'D BY REGISTRAR JAN 16 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			
ACTUAL SIGNATURE JAMES I. BOYD, M. D.				DEPUTY MEDICAL EXAMINER JAMES I. BOYD, M. D.				DATE SIGNED January 7, 1961			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
989 **CERTIFICATE OF DEATH** 00982

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 20 Hr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital				e. STREET ADDRESS 7512 Ridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Girl Middle Cannon Last Cannon				4. DATE OF DEATH Month Jan Day 17 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 16, 1961	
9. AGE (If years last birthday) 20		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS Hours 0 Min 3			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Raymond Ernestus Cannon				14. MOTHER'S MAIDEN NAME Elizabeth Ann Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Mother Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Long atelectasis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Uterine tumor							
(c) Immediate birth 790-001							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 16 1961 to Jan 17 1961 , that (I) (we) last saw the deceased alive on 19 61 , and that death occurred at 8:15A from the causes and on the date stated above							
22a. SIGNATURE <i>[Signature]</i>				22b. ADDRESS 6827 ANNAPOLIS Rd. WOODBRIDGE HILLS			
22c. PHYSICIAN'S NAME (Type) C. GEORGE HARDY				22d. ADDRESS 6827 ANNAPOLIS Rd. WOODBRIDGE HILLS			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/18/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE JAN 20 '61	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from the papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

990

CERTIFICATE OF DEATH

Reg. Dist. No.

00983

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY				c. LENGTH OF STAY IN 1b 4 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SEAT PLEASANT	
d. NAME OF HOSPITAL (If not in hospital, give street address) PRINCE GEORGES GENERAL HOSPITAL				d. STREET ADDRESS 604 63rd Pl.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CASSIUS First		Middle E.		Last CARRICK		4. DATE OF DEATH Month JAN. Day 15 Year 1961	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 16 1888	
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 72 Days 15 Hours 15 Min 61		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done, or if retired, working life, even if retired) RETIRED				10b. KIND OF BUSINESS OR INDUSTRY D.C. SCHOOL EMP.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME William E. Carrick				14. MOTHER'S MAIDEN NAME Mary F. Ward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 579010402		INFORMANT Address FRANCES R. CARRICK SAME AS # 2 (wife)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) PULMONARY CONGESTION 420 DUE TO ARTERIO SCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROTIC HEART DISEASE DUE TO (c) ARTERIO SCLEROTIC HEART DISEASE							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Duodenal Peptic Ulcer & Hemorrhage							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Form 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN. 11 61 , 19 to JAN. 15 , 1961, that I last saw the deceased alive on JAN 15 , 1961, and that death occurred at 2:35 PM , from the causes and on the date stated above ADDRESS (Street, city or town, state) 4500 COLLEGE AVE. COLLEGE PK, Md. DATE SIGNED 1/15/61							
ACTUAL SIGNATURE Wm A. Holbrook, M.D.		PHYSICIAN'S NAME (Type) Wm A. Holbrook, MD. COLLEGE PARK, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/17/61		22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		22d. LOCATION (City, town, or county) (State) XXM Suitland Md.	
23. FUNERAL HOME'S SIGNATURE F. Gasch's Sons ADDRESS 4737 BALTIMORE AVE. HYATT				24a. REC'D BY REGISTRAR DATE JAN 19 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Knead	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

991

CERTIFICATE OF DEATH

Reg. Dist. No.

00984

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Box 123, Route 4</u>			
3. NAME OF DECEASED (Type or print) First <u>Mable</u> Middle <u>Gwendolyn</u> Last <u>Carter</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 Oct. 1876</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John R. Young</u>				14. MOTHER'S MAIDEN NAME <u>Sarah F. Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>James O.R. Carter, Son</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke-Cerebro-Vascular</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerosis, Generalized</u> DUE TO (c) <u>3 days</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan. 1955</u> , to <u>Jan. 2, 1961</u> , that I last saw the deceased alive on <u>2 Jan. 1961</u> , and that death occurred at <u>6 A.M.</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>7315 Landover Rd.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Thomas M. Hutchins</u> M.D. <u>Hyattsville, Maryland - 2/1/61</u>							
PHYSICIAN'S NAME (Type) <u>Thomas M. Hutchins</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/6/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				ADDRESS <u>Mt. Rainier, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

992

Item 8 Film G280 2-3-61

66985

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale MD</u> c. LENGTH OF STAY IN 1b <u>3 hrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Engine Leland Memorial Hosp 1st and Auburn Ave</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale, MD</u> d. STREET ADDRESS <u>1st and Auburn Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Lee Cartmell</u> First Middle Last			4. DATE OF DEATH <u>1-25-1961</u> Month Day Year		
5. SEX <u>male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1877-12-12</u>	9. AGE (In years, last birthday) <u>83</u> yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>William Cartmell</u>			14. MOTHER'S MAIDEN NAME <u>Susan Cox</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>578-09-9557</u>		
17. INFORMANT <u>Hospital Records, Riverdale MD</u> Address			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Charles House</u> PHYSICIAN'S NAME (Type)			22b. DATE SIGNED <u>1-25-61</u> ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		
22c. ADDRESS <u>15541 Columbia Road Burtonsville Md.</u>					
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 27, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. Dasch's Sons</u> ADDRESS <u>Hyattsville Maryland</u>			25a. REC'D BY REGISTRAR <u>JAN 27 '61</u> DATE		
			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institut an Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Pr Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Island Memorial Hosp</u>				d. STREET ADDRESS <u>R 7 D - Bx 282</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Herbert</u> Last <u>Chalmers</u>				4. DATE OF DEATH Month <u>Jan</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>wh</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>6-20-81</u>	
9. AGE (In years last birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u>		IF UNDER 24 HRS. Hours <u>15</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>B & O Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Chas. James Chalmers</u>				14. MOTHER'S MAIDEN NAME <u>House Simonson</u>			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>111-11-1111</u>		17. INFORMANT <u>Hospital Record</u> Address <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO (b) <u>Cerebral vascular Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1 wk.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at _____ M, from the causes and on the date stated above							
22a. SIGNATURE <u>Charles House</u>				M D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>1-15-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles House</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>1/18/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Truman Schwalb</u> ADDRESS <u>3512 Frederick Ave. (29)</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
994 CERTIFICATE OF DEATH

02194

1. PLACE OF DEATH o. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE'S</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HUNTSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PRINCE GEORGE'S GENERAL HOSP.</u>				d. STREET ADDRESS <u>N - STREET</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABy Boy CHASE</u>				4. DATE OF DEATH Month Day Year <u>1 13 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-12-61</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Leon Chase</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE DAKAS Harrod</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mother</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Attacked</u> <u>762.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 12</u> 19 <u>61</u> to <u>Jan. 13</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>Jan. 12</u> 19 <u>61</u> , and that death occurred at <u>12AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John W. Pankin</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>Jan. 20, 1961</u>		<u>Prince George's Gen. Hosp</u>		<u>Cheverly, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HARRY W. PENN, ADM.</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

77234XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

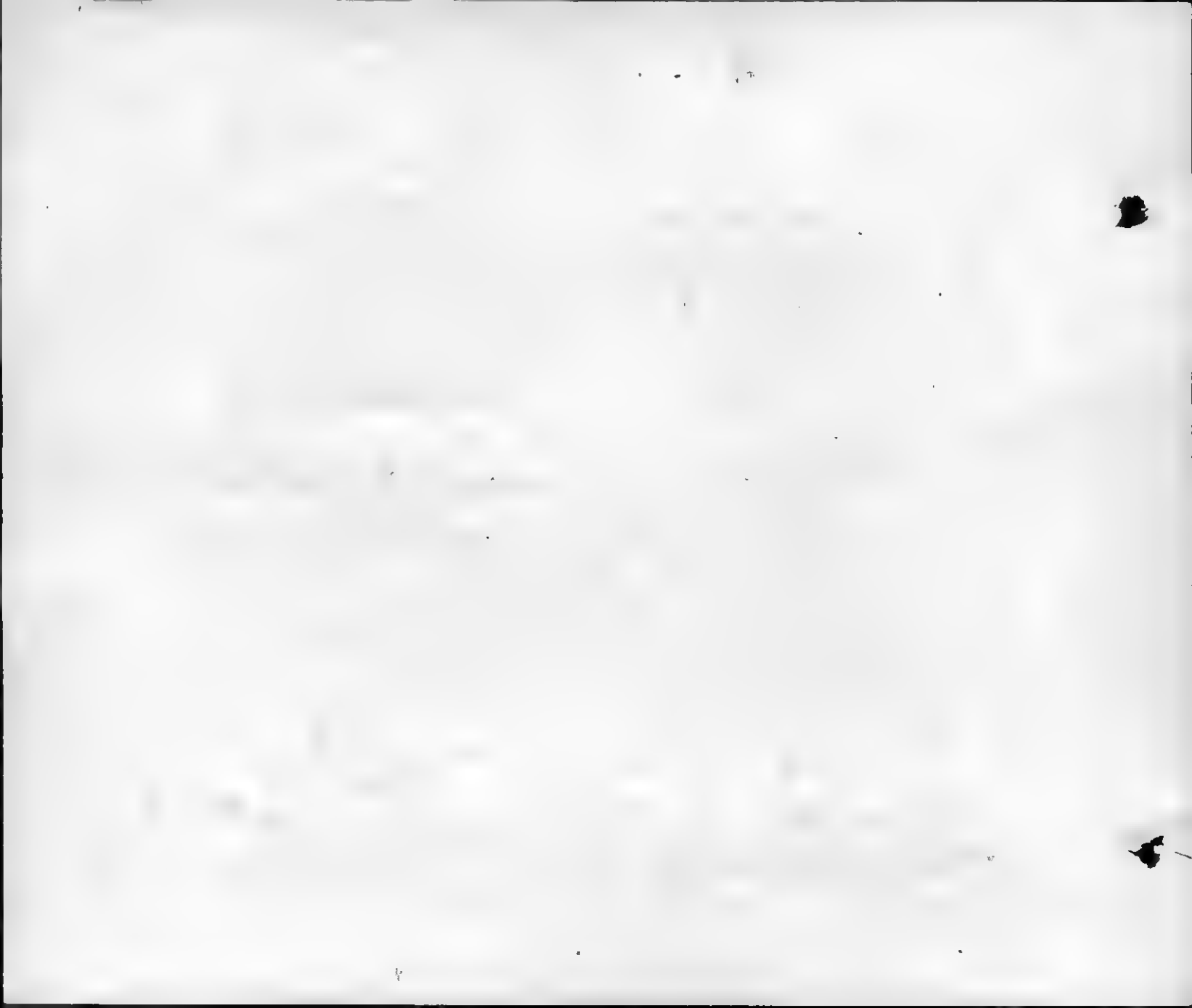
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00987

995

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park Md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Beland Memorial Hosp</u>				d. STREET ADDRESS <u>18902 Baltimore Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>Neal</u> First <u>J.</u> Middle <u>Chase</u> Last				4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-24-10</u>	
9. AGE (In years last birthday) <u>50</u> yrs		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Triangle Motors</u>		11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clarence Chase</u>				14. MOTHER'S MAIDEN NAME <u>Maggie E Lynch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO <u>7-45-</u>		17. INFORMANT <u>Sister in law</u>		18. ADDRESS <u>4901 Harford Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Blinding duodenal</u> DUE TO (b) <u>Blinding duodenal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>1960</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1938</u> to <u>1961</u> , that (I) (we) last saw the deceased alive on <u>1961</u> , and that death occurred at <u>11:00</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. ADDRESS <u>[Address]</u>		22c. DATE SIGNED <u>12/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Name]</u>				22d. ADDRESS <u>[Address]</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 18, 1961</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Arlington National</u>		23d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>				ADDRESS <u>Hyattsville Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 19 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

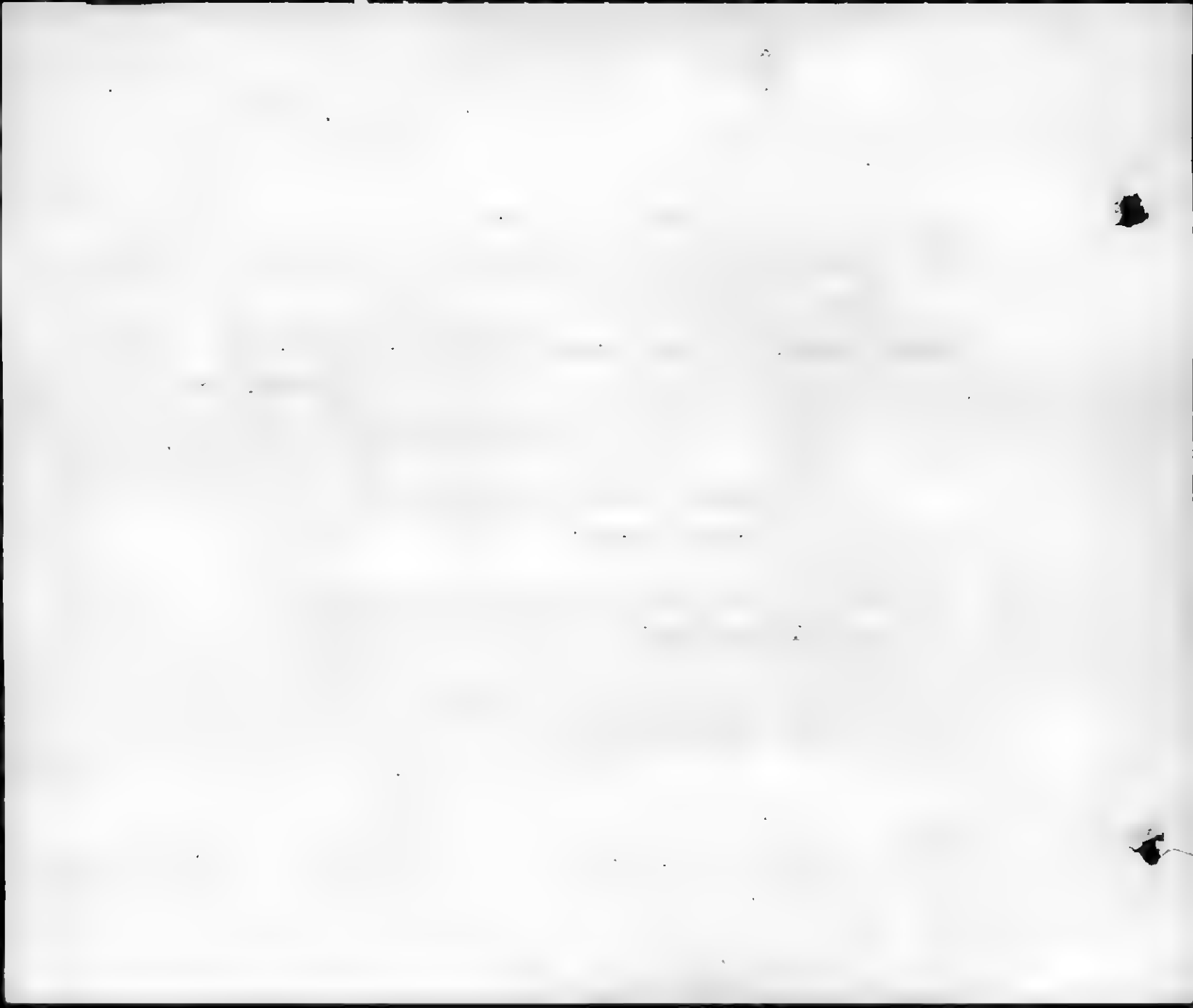


may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
996 **CERTIFICATE OF DEATH**

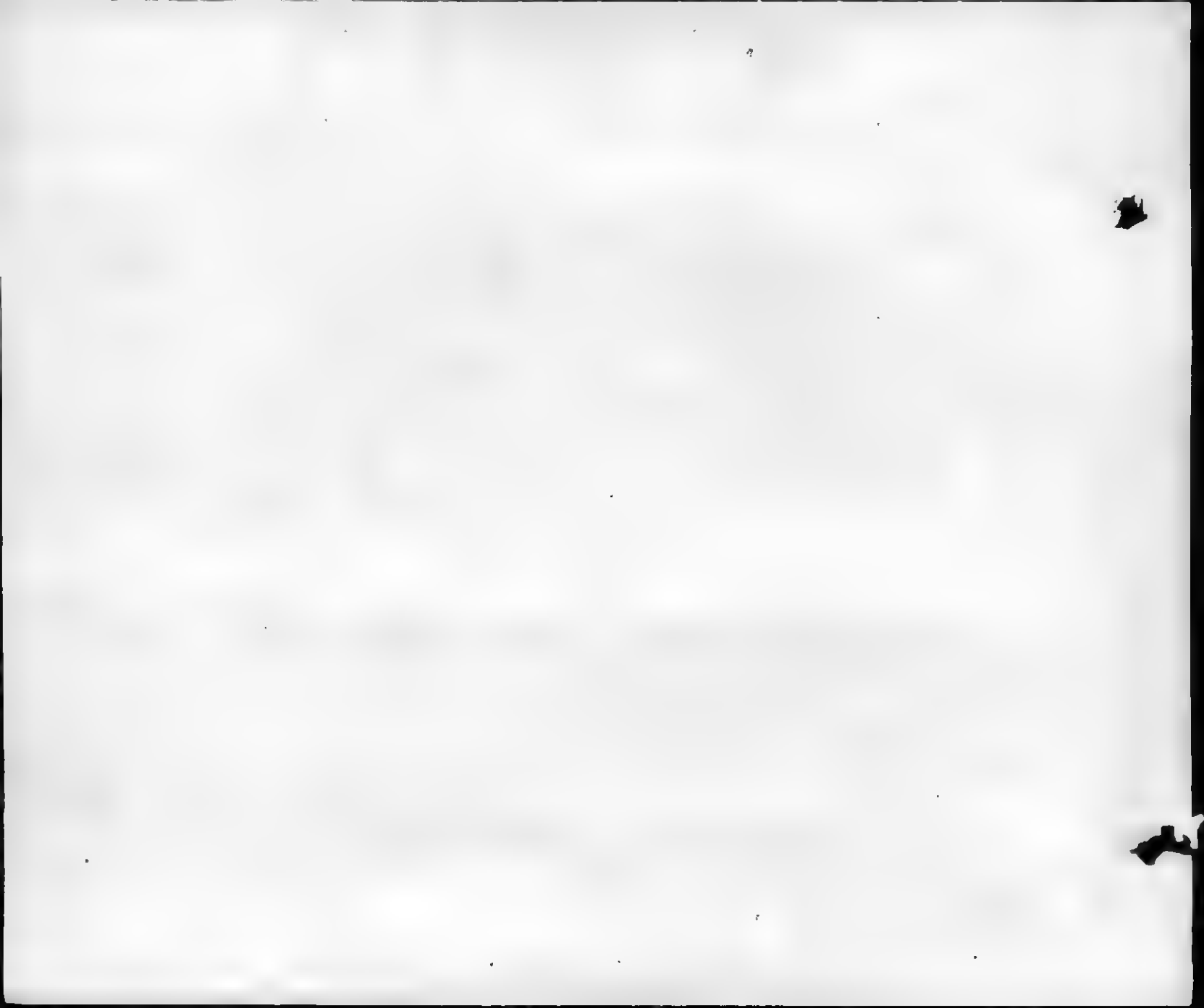
66988

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE'S</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>BRENTWOOD</u> b. COUNTY <u>PG</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>				c. LENGTH OF STAY IN 1b <u>16</u> <u>MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALICE</u> Middle <u>M.</u> Last <u>CLANCY</u>				4. DATE OF DEATH Month <u>1</u> - Day <u>26</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-10-93</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>7</u>		11. IF UNDER 24 HRS Hours <u>6</u> Min <u>7</u>		12. IF UNDER 24 HRS Hours <u>6</u> Min <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>			
11. BIRTHPLACE (State or foreign country) <u>Washington DC</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Raymond T. Baur</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>3822-37th Place, Brentwood, Md.</u>			
17. INFORMANT <u>Robert J. Clancy, son</u>				18. ADDRESS <u>3822-37th Place, Brentwood, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Cerebral Thromboses</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) _____							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Pulmonary Emboli</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>1-13</u> <u>1961</u> , to <u>1-26</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11AM</u> , from the causes and on the date stated above							
22a. SIGNATURE <u>Gorden W. Kelly</u>				22b. DATE SIGNED <u>1-26</u>			
22c. PHYSICIAN'S NAME (Type) <u>GORDEN W. KELLY</u>				22d. ADDRESS <u>6124-45th Ave. Hyattsville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 30/61</u>		<u>Mt. Olivet Cemetery</u>		<u>Washington, DC.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kelly's Funeral Home Inc.</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 1 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>C. L. Finner</u>							



997
 66889
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

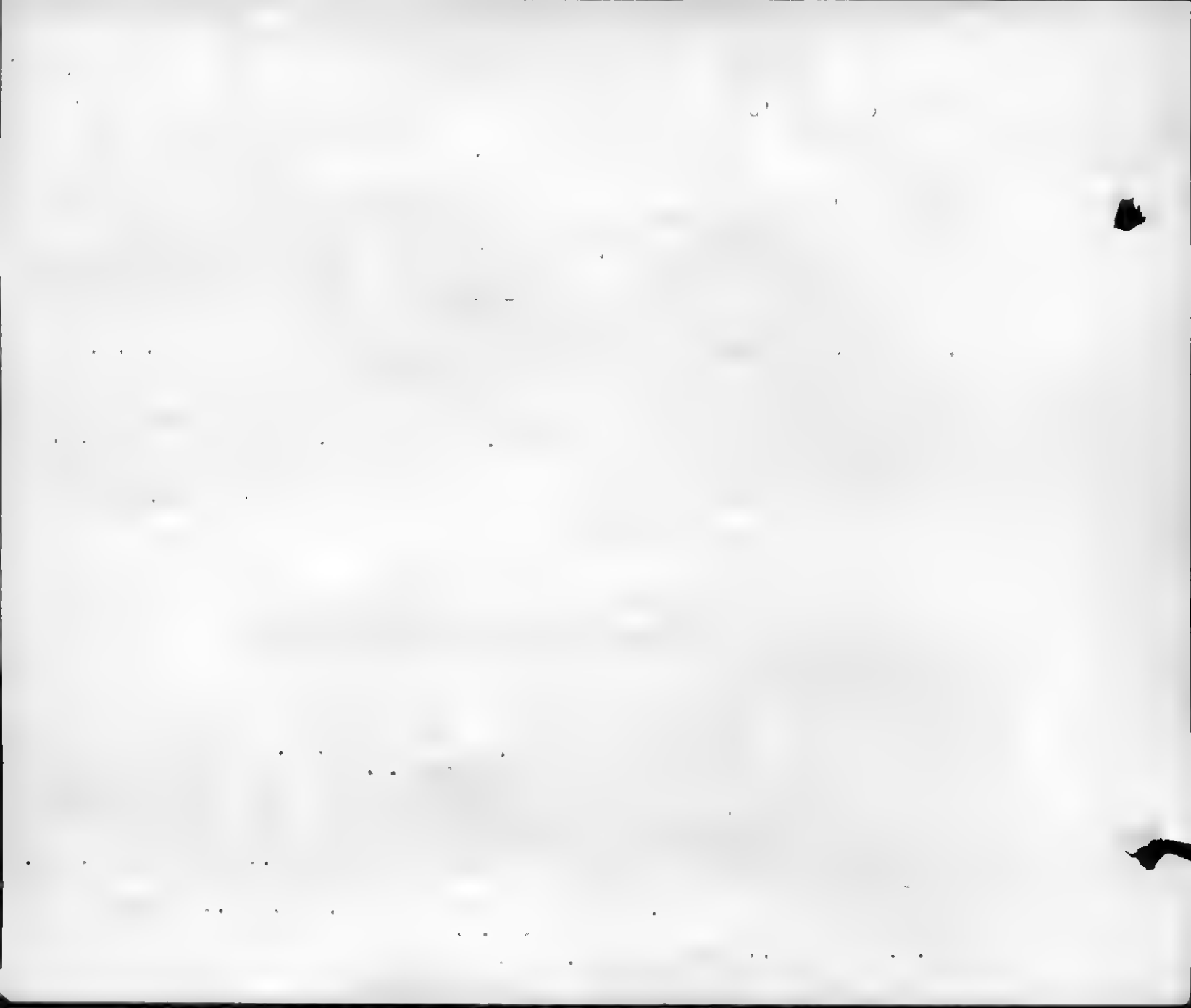
1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leland Memorial Hospital				d. STREET ADDRESS Rose Mary Lane			
3. NAME OF DECEASED (Type or print) First Middle Last Lucy ELIZABETH WINSTON Clay				4. DATE OF DEATH Month Day Year Jan. 27 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-12-1874	9. AGE (In years last birthday) 86 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Ambrose W. Winston.				14. MOTHER'S MAIDEN NAME Lellia Lee Rucker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO —		17. INFORMANT Winston Clay Address 7200 Wells Parkway			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA + UREMIA 539.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ESOPHOGEAL DIVERTICULUM IN NECK DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GANGRENE of bowel due to adhesions treated successfully by surgery							INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 8:25 AM , from the causes and on the date stated above.							
22a. SIGNATURE Wilkinson				22b. DATE SIGNED Jan 27, 1961			
22c. PHYSICIAN'S NAME (Type) Dr. Wilkinson				22d. ADDRESS Leland Hospital Riverdale Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Transportation		Jan 29, 1961		Alta Vista		Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE A. Gasch's Sons				ADDRESS Hyattsville, Maryland.		25a. REC'D BY REGISTRAR DATE FEB 2 '61	
				25b. REGISTRAR'S SIGNATURE Charles S. Kincaid			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
998 **CERTIFICATE OF DEATH** **66998**

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 12 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				e. STREET ADDRESS 4200 Sheridan Street			
3. NAME OF DECEASED (Type or print) First George Middle C. Last Cook				4. DATE OF DEATH Month January Day 21 Year 19 61			
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5-19-1895	9. AGE (In years last birthday) 65 yrs	10. UNDER 1 YEAR Months 65 Days 0 Hours 0 Min 0	11. UNDER 24 HRS Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres. Henry B. Cook Co., Food Brokerage				10b. KIND OF BUSINESS OR INDUSTRY Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Harry B. Cook				14. MOTHER'S MAIDEN NAME Lulu Pfaff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16 SOCIAL SECURITY NO. 212-07-9369		17. INFORMANT Address Daughter Mrs. Marjorie C. Howard N.J.	
18 CAUSE OF DEATH [Enter only one cause per (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 584X IMMEDIATE CAUSE (a) Buried pneumonia and Pulmonary embolism DUE TO (b) Cholangitis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO (c) Cholangitis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obstruction of common bile duct by gallstones - surgically removed							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 5:50 P.M.			
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4314 Gallatin St., Hyattsville, Md.	
21 I certify that (I) (this hospital) attended the deceased from Jan. 10 19 61 to Jan. 21 19 61 that (I) (we) last saw the deceased alive on Jan. 21 19 61 and that death occurred 5:50 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Aaron Deitz				22b. DATE SIGNED Jan 25 1961			
22c. PHYSICIAN'S NAME (Type) Aaron Deitz				22d. ADDRESS 4314 Gallatin St., Hyattsville, Md.			
23a. BURIAL, CREMATION, REMAINS (Specify)		23b. DATE THEREOF 1/24/61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Pr. Geo. Co., Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE The S.H. Hines Co., 2901 14th St. N.W.				25a. REC'D BY REGISTRAR JAN 25 '61		25b. REGISTRAR'S SIGNATURE <i>W. J. Howard</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
999 **CERTIFICATE OF DEATH**

66991

1. PLACE OF DEATH a. COUNTY PRINCE George <small>MARYLAND</small>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chillum				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHILLUM 50			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6011 Riggs ROAD				d. STREET ADDRESS 6011 Riggs ROAD 1			
3. NAME OF DECEASED (Type or print)		First ELLEN Middle COUMARIS Last		4. DATE OF DEATH		Month JAN Day 17 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ?		9. AGE (In years last birthday) 73	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? ALIEN U.S.A.	
13. FATHER'S NAME PETER BELITZOS				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT LOUIS COUMARIS (SON)		Address 6011 Riggs Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 48 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/15 19 57 to 1/17 19 61 , that (I) (we) last saw the deceased alive on 1/17 19 61 , and that death occurred at 8:30 PM, from the causes and on the date stated above.							
22a. SIGNATURE James C Mandes				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JAMES C MANDES				22d. ADDRESS 1401 16th St. N.W. Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/21/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co. Washington, D. C.				25a. REC'D BY REGISTRAR DATE JAN 19 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1000

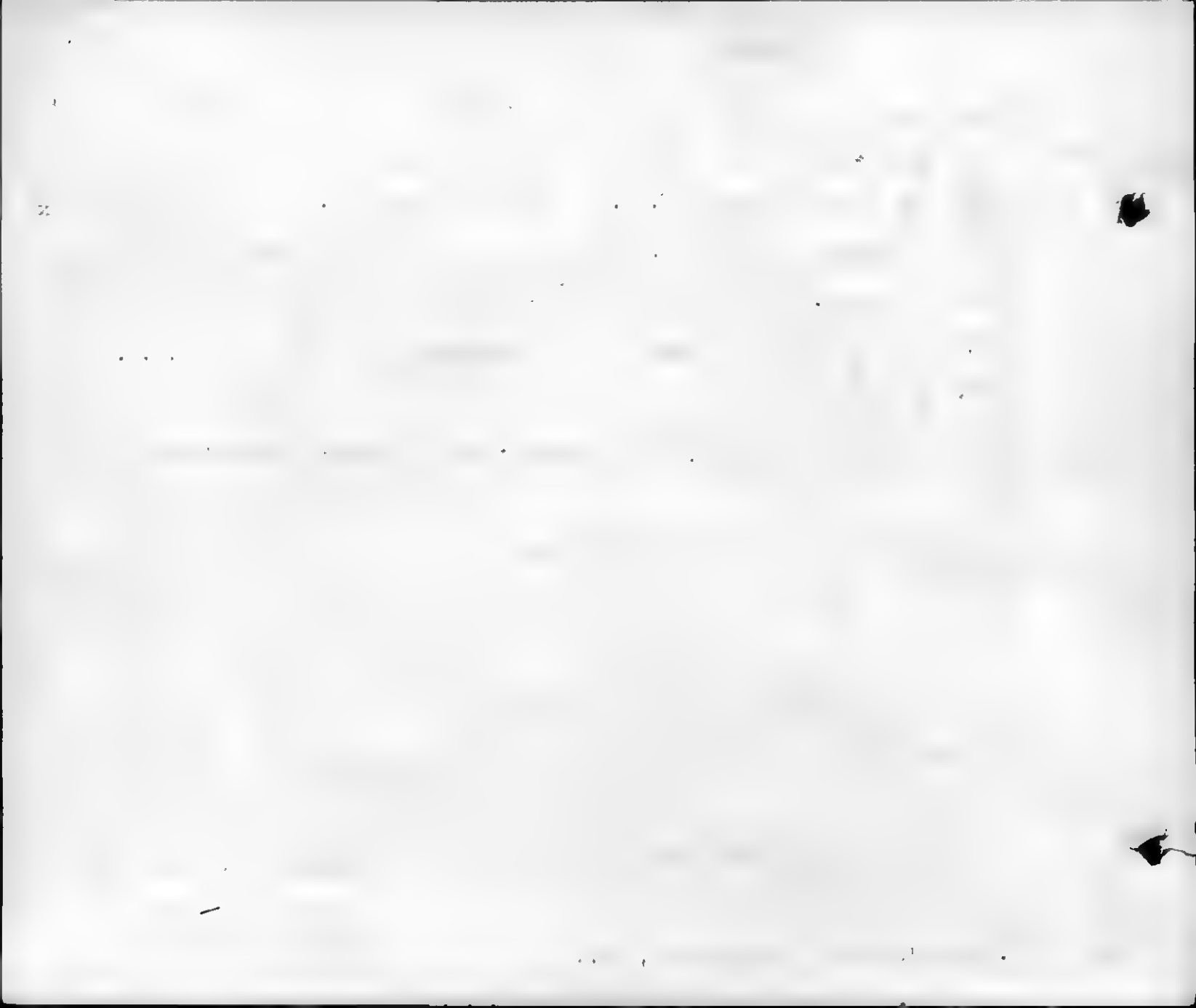
CERTIFICATE OF DEATH

Reg. Dist. No. 00992

1. PLACE OF DEATH a. COUNTY MARYLAND Prince George's				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) 6405 Ager Road (Mrs Bells N. H.)				d. STREET ADDRESS 8506 Fremont St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last David Lewis Croft				4. DATE OF DEATH Month Day Year Jan 5 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/7/1959		9. AGE (in years last birthday) yrs. 2	10. IF UNDER 1 YEAR Months Days Hours Min. 5
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hal. Lewis Croft				14. MOTHER'S MAIDEN NAME Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Hal L. Croft (Father) Same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute upper respiratory infection 25.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital heart disease DUE TO (c) Mongolism						INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug - 5, 1960 to 1/5, 1961 , that I last saw the deceased alive on 1/5, 1961 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6905 Balto Blvd College Park, Md. DATE SIGNED 1/5/61 ACTUAL SIGNATURE Thomas A. Christensen M.D. PHYSICIAN'S NAME (Type) Thomas A Christensen							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 9, 1961		22c. NAME OF CEMETERY OR CREMATOR Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md..		24a. REC'D BY REGISTRAR DATE JAN 13 '61	
				24b. REGISTRAR'S SIGNATURE Carlton S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1001

CERTIFICATE OF DEATH

60993

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (RURAL)			c. LENGTH OF STAY IN 1b 29 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 731 - 5th St., S.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Clarence Middle Last Crutchfield				4. DATE OF DEATH Month January Day 12 Year 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/11/09	
9. AGE (In years lost birthday) 51 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter Crutchfield		14. MOTHER'S MAIDEN NAME Annie Bolden			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Decedent Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchogenic carcinoma with metastases 162.01 DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Carcinoma of pancreas; early cirrhotic changes							INTERVAL BETWEEN ONSET AND DEATH 4 mo.
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 14, 1960 to 1/12/1961 , that (I) (we) last saw the deceased alive on 1/12 19 61 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/12/61			
22c. PHYSICIAN'S NAME (Type) Moe Weiss		22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.					
23a. BURIAL OR CREMATION, REMOVAL (Specify) 1-17-61		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY CHAPEL HILL CEMETERY		23d. LOCATION (City, town, or county) (State) CHAPEL HILL, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John T. Khum & Co.				ADDRESS 3015 12th St. N.E.		25a. REC'D BY REGISTRAR DATE JAN 19 '61	
				25b. REGISTRAR'S SIGNATURE Philip Kay		25c. REGISTRAR'S NAME Philip Kay	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

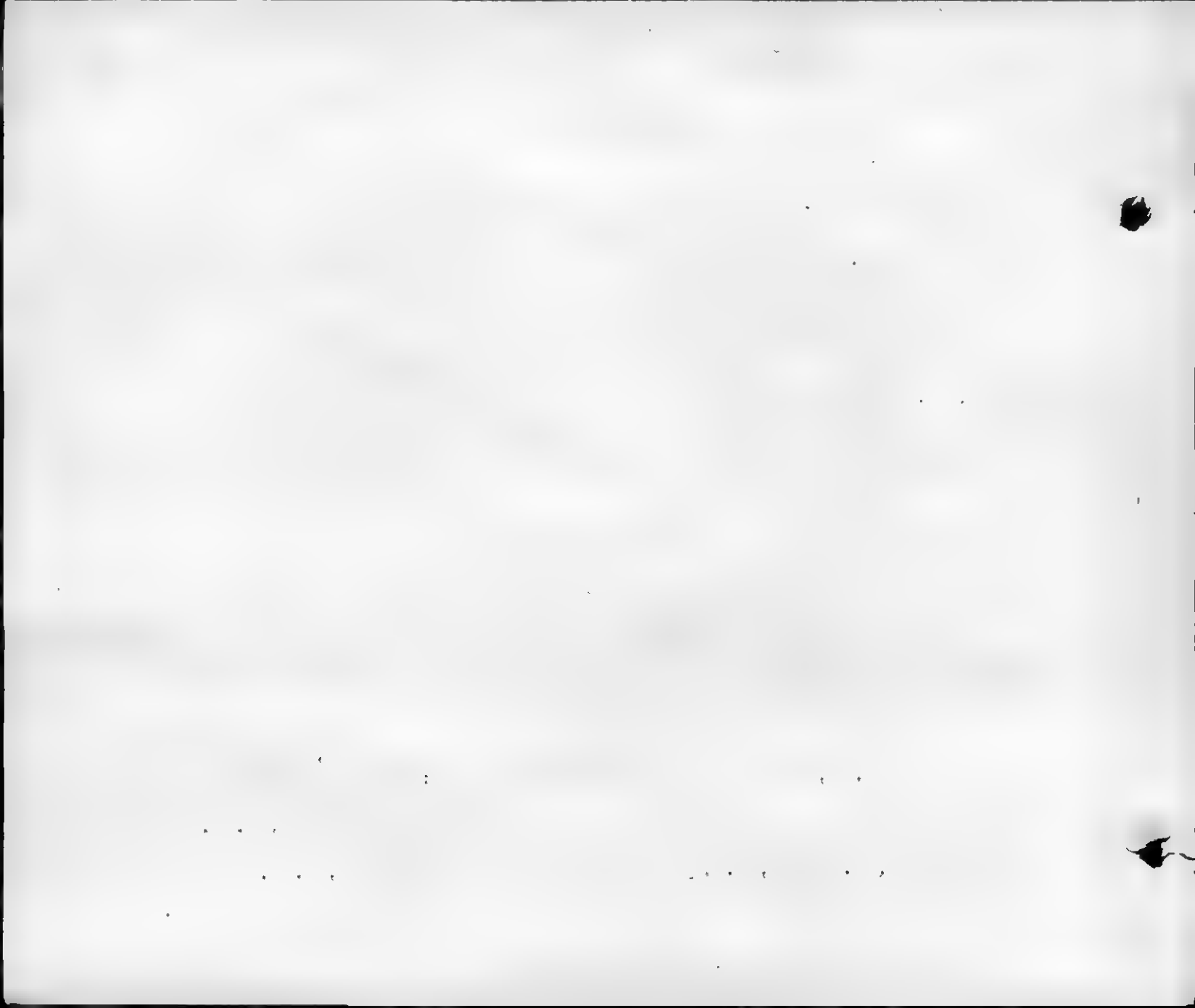
1002

CERTIFICATE OF DEATH

Reg. Dist. No. 60994

1. PLACE OF DEATH a. COUNTY Pr George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside c. LENGTH OF STAY IN 1b Morningside d. NAME OF HOSPITAL (If not in hospital, give street address) 223 Maple Rd.		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Pr George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside d. STREET ADDRESS 223 Maple Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mr. Curtis I Middle Deily Last Deily		4. DATE OF DEATH Month January Day 16 Year 1961	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-83
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Wm. H.H. Dr. Deily		14. MOTHER'S MAIDEN NAME Valeria Faisey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO (If yes, give war or dates of service)	
17. INFORMANT Mrs Lois O'Conner		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Chronic Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterioscleotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 3 months 2 years 1 1/2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1955 , 19____, to Jan 16, 1961 , that I last saw the deceased alive on Jan. 3, 1961 , 19____, and that death occurred at 2:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 200 Marlboro Pike, S. E. DATE SIGNED			
ACTUAL SIGNATURE Sidney W. Lowry		PHYSICIAN'S NAME (Type) S. W. Lowry, M.D.	
22a. BURIAL, CREMATION, REMAINS (Specify) Burial		22b. DATE THEREOF 1-18-61	22c. NAME OF CEMETERY OR CREMATORY Rosemont
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home. Washington D.C.		24a. REC'D BY REGISTRAR Jan 19 61	
24b. REGISTRAR'S SIGNATURE W. S. K...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



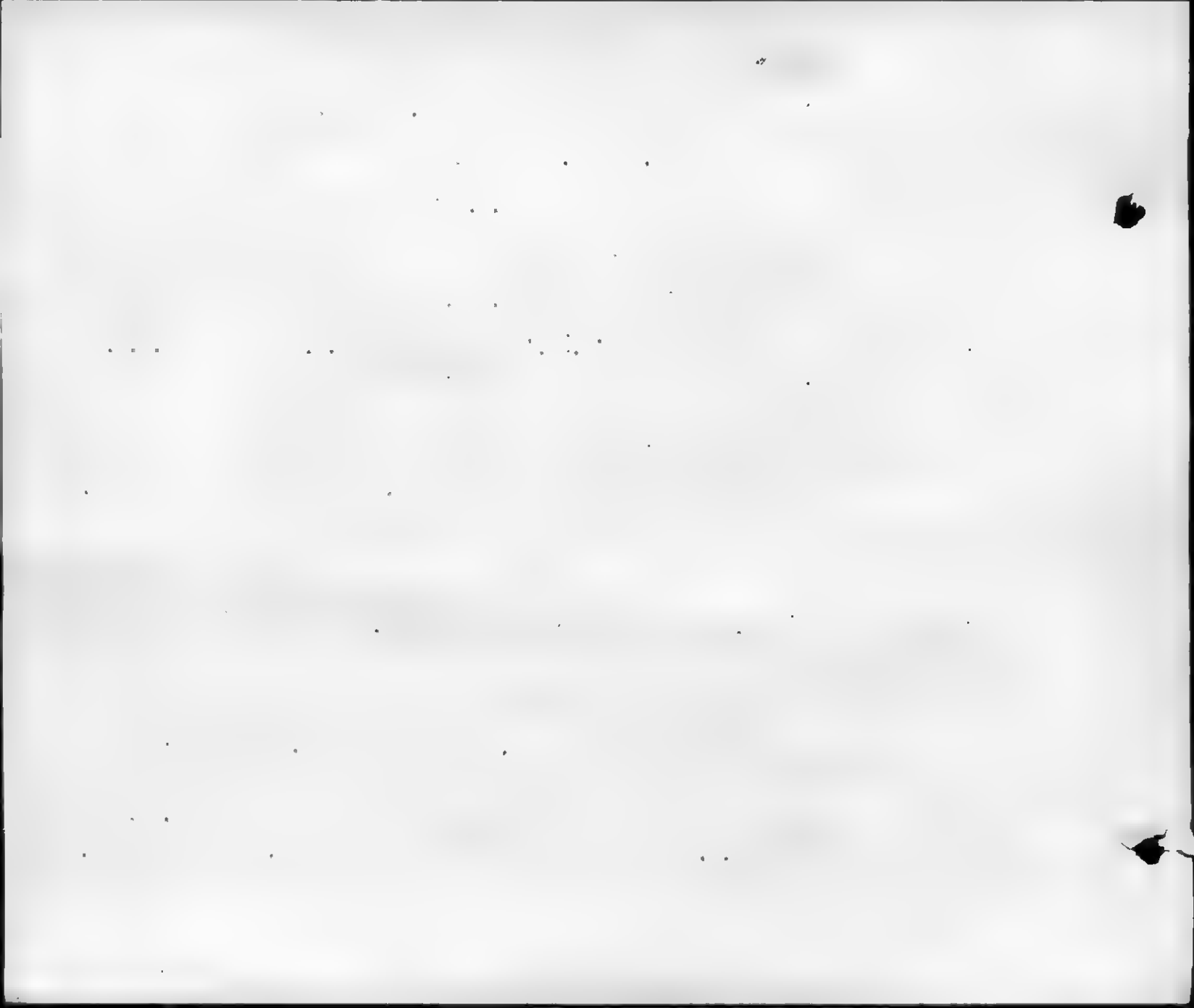
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1003

CERTIFICATE OF DEATH

60995

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Dist. of Col. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Glenn Dale				c. LENGTH OF STAY IN 1b 5 mo. 4 das.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS D.C. Village		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle - Last DONOGHUE				4. DATE OF DEATH Month January Day 7 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 22, 1906	
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cashier		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lawrence Rucker				14. MOTHER'S MAIDEN NAME Nellie Cavanaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. 224-12-2371		17. INFORMANT Person			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident (prob. thrombosis) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 das.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis; Hypertensive Cardiovascular Disease; Myocardial Infarction, remote; Coronary insufficiency.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 3 , 19 60 , to Jan. 7 , 19 61 , that (I) (we) lost saw the deceased alive on Jan. 7 , 19 61 , and that death occurred on Jan. 7 , 19 61 , from the causes and on the date stated above							
22a. SIGNATURE <i>Moe Weiss</i>				22b. DATE SIGNED Jan. 7, 1961			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		1/11/61		MT Olmsted		Wash. D.C.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers, Jr.</i>				ADDRESS 517 11th ST SE		25a. REC'D BY REGISTRAR JAN 12 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

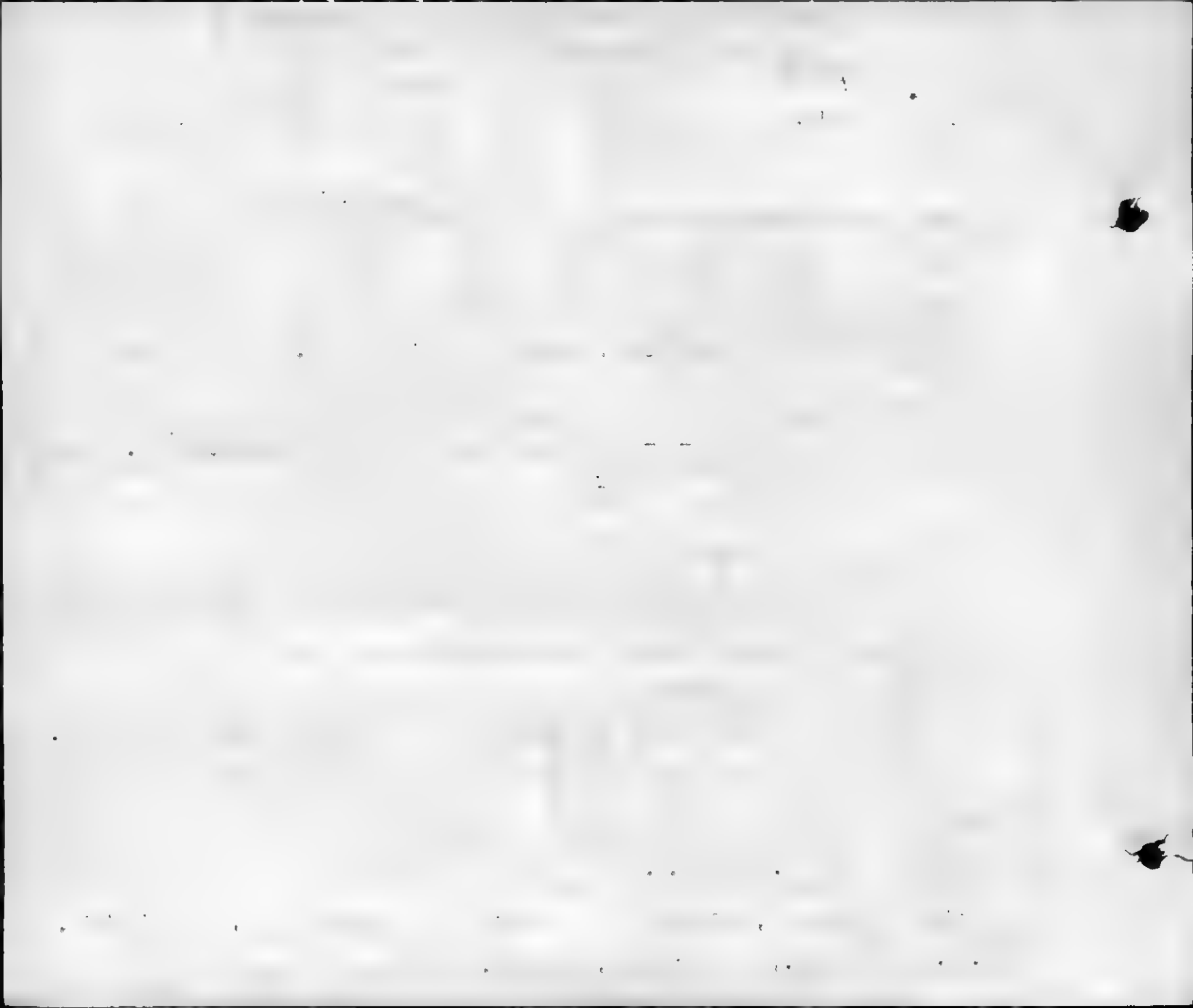
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **60986**

1. PLACE OF DEATH a. COUNTY Prince George's, MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berwyn			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George General Hospital				d. STREET ADDRESS 8519 Potomac Road, Berwyn		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Howard George Dunn				4. DATE OF DEATH Month January Day 3 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/6/84	9. AGE (in years last birthday) 76 yrs.	IF UNDER 1 YEAR Months 7 Days 6	IF UNDER 24 HRS. Hours 8 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY State Roads, Retired		11. BIRTHPLACE (State or foreign country) Franklin Town, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Dunn				14. MOTHER'S MAIDEN NAME Martha Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-14-7426		17. INFORMANT Rebecca Dunn, Wife Address Potomac 8519 Potomac Ave., Berwyn			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sub dural & sub arachnoid hemorrhage 8 days DUE TO Trauma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Trauma DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell to floor					
20c. TIME OF INJURY Month, Day, Year 3:00 p.m. 12/25 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Berwyn Prince George Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James I. Boyd, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James I. Boyd, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF January 6, 1961		22c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery		22d. LOCATION (City, town, or county) (State) Charles Town, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. CHAMBERS CO., ADDRESS Riverdale, Maryland.				24a. REC'D BY REGISTRAR DATE JAN 5 '61		24b. REGISTRAR'S SIGNATURE C. S. Kline	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1005 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

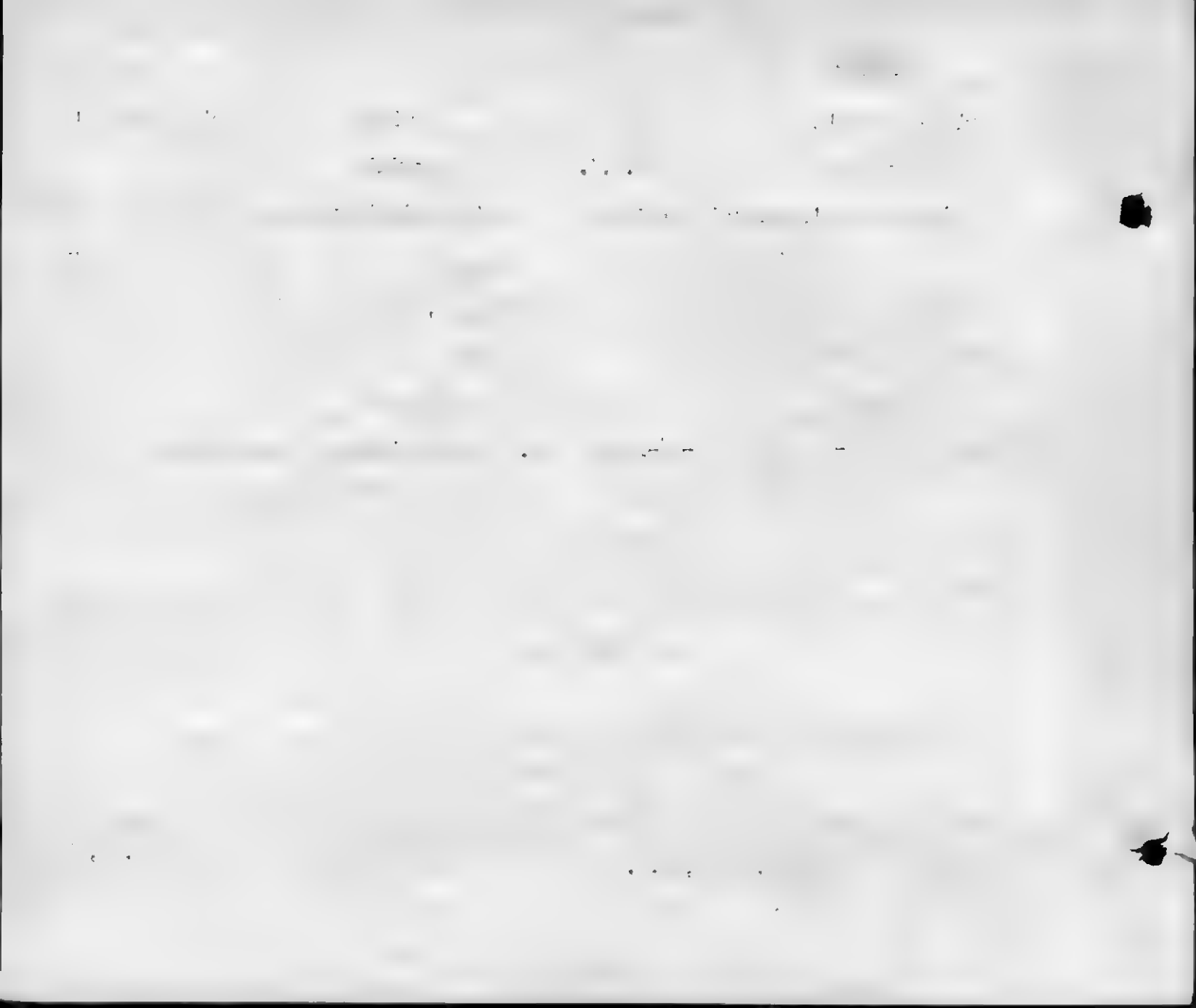
Item 12 Film G280-2-2-61 et

10997

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 15 D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 9406 Adelphi Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William George Dutton		4. DATE OF DEATH Jan 2 1961		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 17, 1888	
9. AGE (In years last birthday) 72 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Worker Ship Yard		11. BIRTHPLACE (State or foreign country) England	
12. CITIZEN OF WHAT COUNTRY? Great Briton		13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 127-14-1318		17. INFORMANT Mr. Everett Wilson Address Same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive heart failure DUE TO Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE James I. Boyd NAME (Type) JAMES I. BOYD, M.D. DATE SIGNED Jan. 3, 1960					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/61		22c. NAME OF CEMETERY OR CREMATORY ROCK HILL	
22d. LOCATION (City, town, or country) (State) STAFFORD VA.		23. FUNERAL DIRECTOR W.W. CHAMBERS CO. 1400 CHAPIN ST NW WASHINGTON D.C.		24a. REC'D BY REGISTRAR DATE JAN 9 '61	
24b. REGISTRAR'S SIGNATURE Robert S. Kraus					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 FOR STATE HEALTH DEPT. M 097 1 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. VS. AISME 5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1006 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6698

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Prince Georges</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u> <u>Deed married</u></p> <p>c. LENGTH OF STAY IN 1b <u>1</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince Georges General Hospital</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u></p> <p>d. STREET ADDRESS <u>4414 Oliver</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) <u>Kenneth Carter</u></p> <p>4. DATE OF DEATH <u>January 10 1961</u></p> <p>5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 24 1909</u></p> <p>9. AGE In years (If UNDER 1 YEAR, last birthday) <u>51</u> yrs. Months <u>1</u> Days <u>10</u> Hours <u>10</u> Min. <u>57</u></p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u></p> <p>10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u></p> <p>11. BIRTHPLACE (State or foreign country) <u>North Dakota</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S. &</u></p>	
<p>13. FATHER'S NAME <u>Peter Fahey</u> <u>261-32-0157</u></p> <p>14. MOTHER'S MAIDEN NAME <u>Maureen</u></p> <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>will</u> 16. SOCIAL SECURITY NO. <u>261-32-0157</u> 17. INFORMANT <u>Elizabeth Fahey, same as #2</u></p>		<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute congestive heart failure</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Coronary occlusion</u></p> <p>(c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>same as #2</u></p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p> <p>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)</p>		<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u></p> <p>20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p> <p>ACTUAL SIGNATURE <u>James I. Boyle</u> M.D. DATE SIGNED <u>January 10, 1961</u></p> <p>EXAMINER'S NAME (Type) <u>James I. Boyle</u> Address (Street, city, town, or county) <u>Arlington Virginia</u></p>			
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p> <p>22b. DATE THEREOF <u>1-12-61</u></p> <p>22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u></p> <p>22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u></p>		<p>23. FUNERAL DIRECTOR <u>W.W. Chambers Co. Riverdale, Md</u> ADDRESS</p> <p>24a. REC'D BY REGISTRAR <u>Arthur L. Knaul</u> 24b. REGISTRAR'S SIGNATURE</p> <p>DATE JAN 12 '61</p>	



14
FOR STATE
HEALTH DEPT.

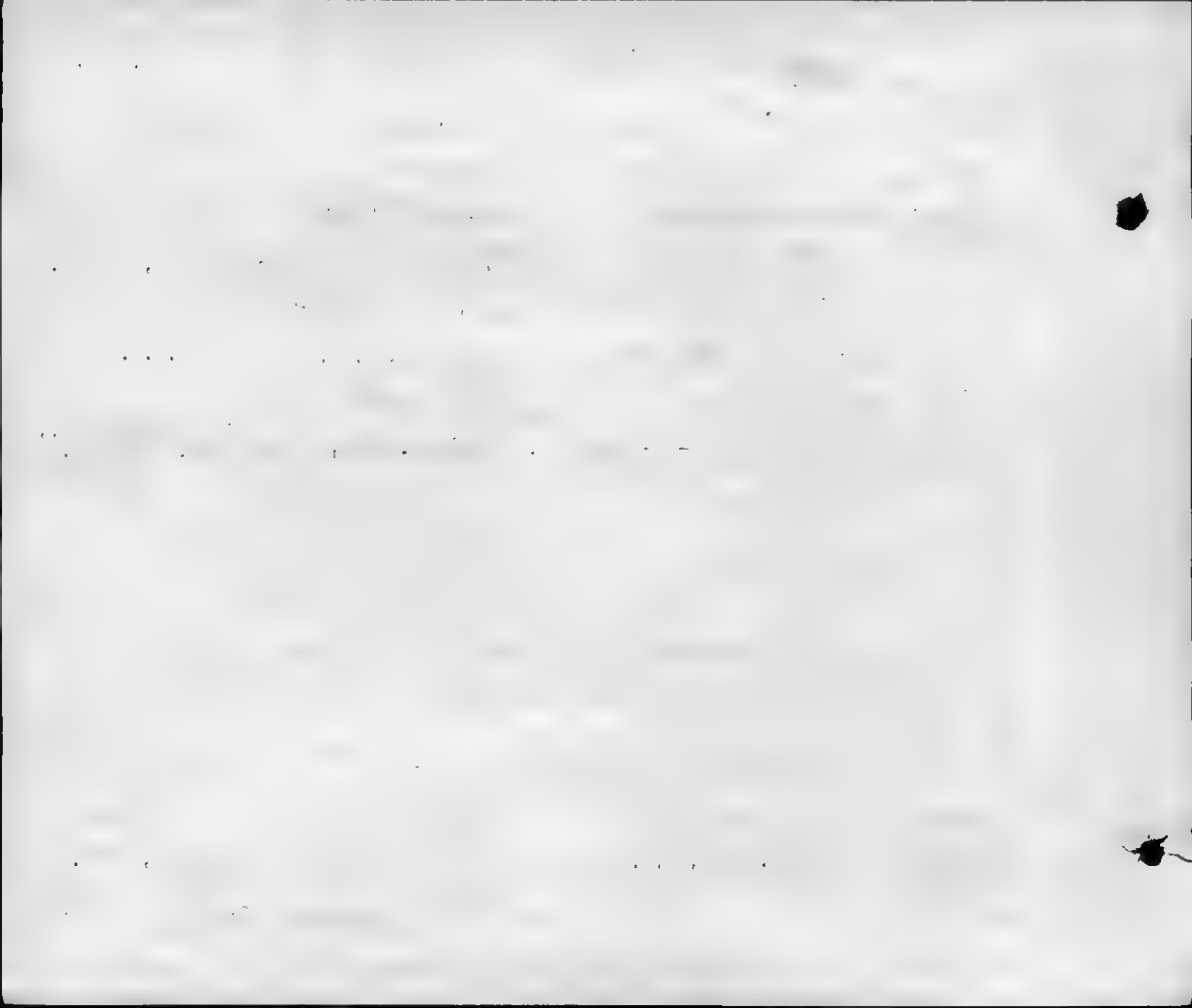
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed by the Deputy Medical Examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

VS. A15ME
SM 7/59

1007
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

61000

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN MD DOA d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Edmonston d. STREET ADDRESS 4706 Decatur Street	
3. NAME OF DECEASED (Type or print) GEORGE URIAS FANT		4. DATE OF DEATH Month January Day 26 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 26, 1906	
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months 54 Days 26 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern Owner		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wilton Fant		14. MOTHER'S MAIDEN NAME Nannie Cooper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 578-05-8566	
17. INFORMANT Mrs. Dorothy M. Fant,		Address 4706 Decatur St., Edmonston, Maryland.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.0 DUE TO (b) Anterior coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 26, 1960.			
ACTUAL SIGNATURE JAMES I. BOYD, M.D. NAME (Type)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 1/30/61		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
22d. LOCATION (City, town, or country) (State) Colmar Manor, Md.		23. FUNERAL DIRECTOR F. Gasch's Sons	
ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR JAN 30 '61	
24b. REGISTRAR'S SIGNATURE Charles E. Hume			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A'S (4)
 ISM 11/59

1008

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

00993

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deland Memorial Hospital</u>				d. STREET ADDRESS <u>914 Montgomery St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Cora Elizabeth Parrish</u>				4. DATE OF DEATH Month Day Year <u>January 27 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>29 1874</u>	9. AGE (in years last birthday) <u>86</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Henning Beall</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Burdette</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Calvin Parrish Laurel, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Frailty & General Atrophic Senescence</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Frailty & General Atrophic Senescence</u> (c) <u>Frailty & General Atrophic Senescence</u> DUE TO							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>March 11 1960</u> to <u>January 27 1961</u> , that (I) (we) last saw the deceased alive on <u>January 27 1961</u> , and that death occurred at <u>7:45</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert C. Wingfield</u>				22b. DATE SIGNED <u>January 29, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>				22d. ADDRESS			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/30/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Long Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Laurel, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Connelton, Laurel, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 1 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur J. Evans</u>	

I



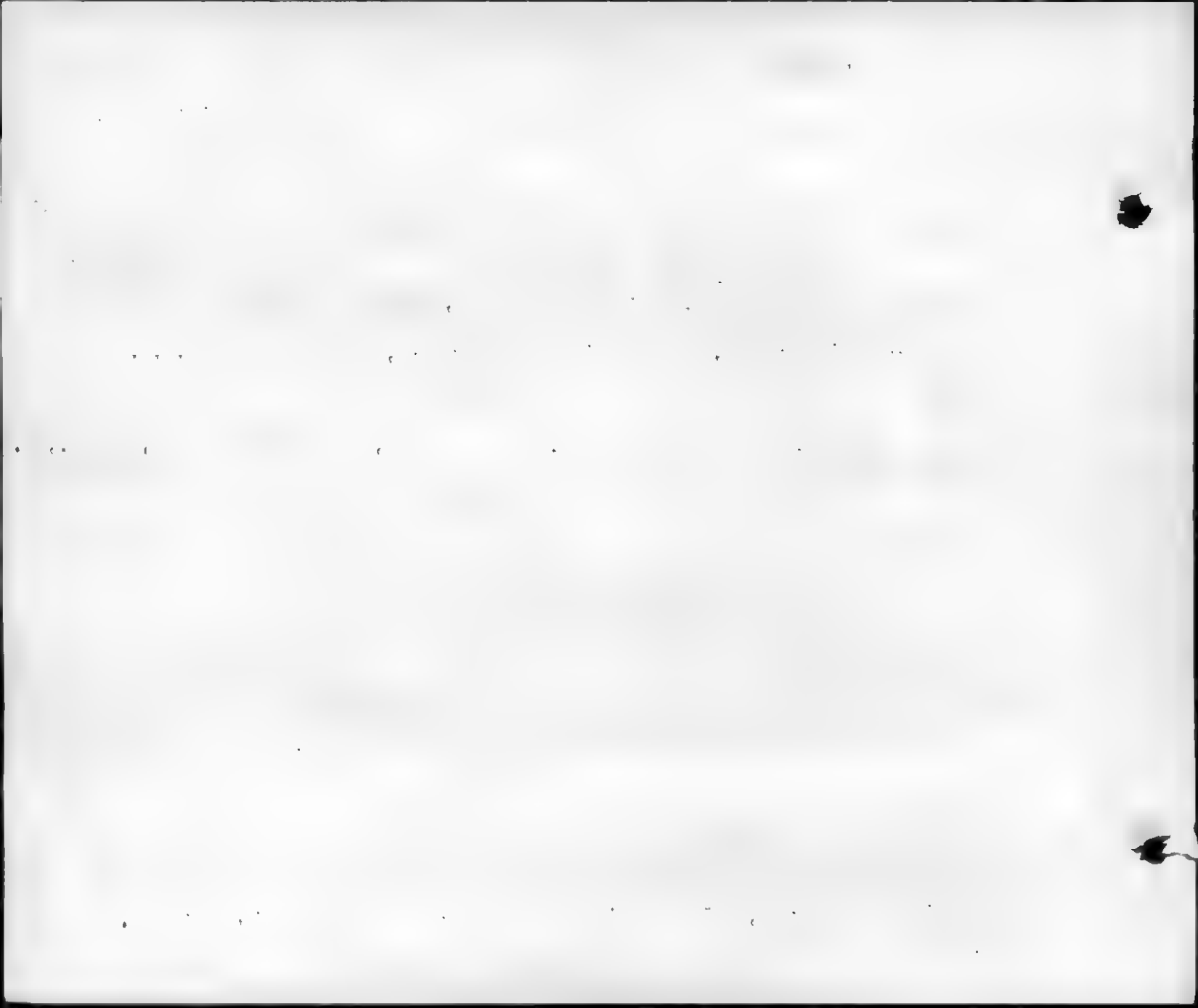
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1009

1106

1 PLACE OF DEATH a COUNTY <u>Prince George's</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <u>Md.</u> b COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesley</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Prince George's General Hospital</u>				d. STREET ADDRESS <u>6103 Sargent Rd.</u>			
3 NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>HOWELL</u> Last <u>FARLIN</u>				4. DATE OF DEATH Month <u>JAN.</u> Day <u>7</u> Year <u>1961</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1884</u>	9 AGE (In years last birthday) yrs <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer Ret. Construction</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Interlaken, New York</u>		11 BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Unknown</u>				14 MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17 INFORMANT Address <u>F. Roger Eastman, 6103 Sargeant Road, Hyatts., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4 years</u> (c) <u>6 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Alumina</u>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>OCT. 1960</u> to <u>1/7</u> , 1961, that (I) (we) lost the deceased alive on <u>1/7</u> , 1961, and that death occurred at <u>12 PM</u> , from the causes and on the date stated above							
22a SIGNATURE <u>Dr. Norman D. Comaul</u>				22b DATE SIGNED <u>1/7/61</u>		22c PHYSICIAN'S NAME (Type) <u>Dr. NORMAN COMAUL</u>	
22d ADDRESS <u>3503 Ring W. Mt Rainier Md.</u>							
23a BURIAL, CREMATON, REMOVAL (Specify) <u>Cremation</u>		23b DATE THEREOF <u>January 9, 1961</u>		23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City, town, or county) (State) <u>Blodensburg, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. R. Chamber. G. 5001 Cle. and Ave. Riverdale</u>				25a. REC'D BY REGISTRAR <u>DATE JAN 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. H...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

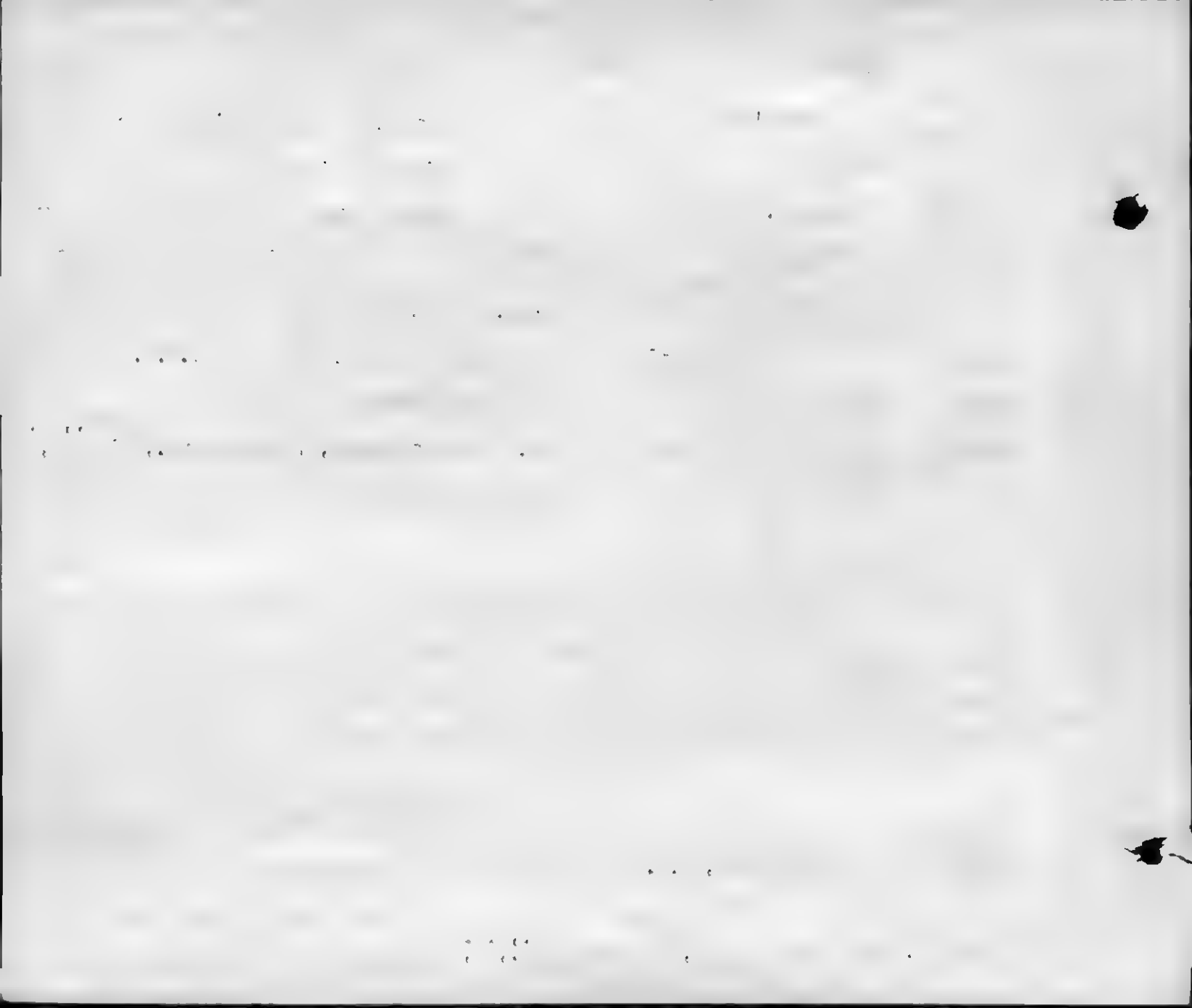
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1010 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(1002)

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairmont Heights			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fairmont Heights		
c. LENGTH OF STAY IN 1b 5 years			d. STREET ADDRESS 5911 K Street		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Behind 5911 K St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Thomas GALLOWAY			4. DATE OF DEATH Jan 9 19 61		
5. SEX Male			6. COLOR OR RACE Negro		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Jan 18 1886		
9. AGE (In years last birthday) 74 yrs.			10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY General		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Galloway			14. MOTHER'S MAIDEN NAME Rhoda Duckett		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown			16. SOCIAL SECURITY NO. Unknown		
17. INFORMANT Mrs. Betty Patterson			Address Hgts., Md., 722 61st Ave., Fairmont,		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 932.0 DUE TO Exposure to cold Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Exposure in unheated building during cold wave		
20c. TIME OF INJURY Month, Day, Year Jan 9 19 61			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			20f. (City or town) Fairmont Heights (County) Prince Georges (State) Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) James I Boyd, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-14-61			22b. DATE THEREOF 1-14-61		
22c. NAME OF CEMETERY OR CREMATORY Wash. D.C. Harmony Park			22d. LOCATION (City, town, or country) Highland PK Md		
23. FUNERAL DIRECTOR HENRY S. WASHINGTON & SONS, 4927 Deane Ave., NE, Wash. D.C.			24a. REC'D BY REGISTRAR Jan 16 '61		
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			DATE SIGNED 10 Jan 1961		



FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10M3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

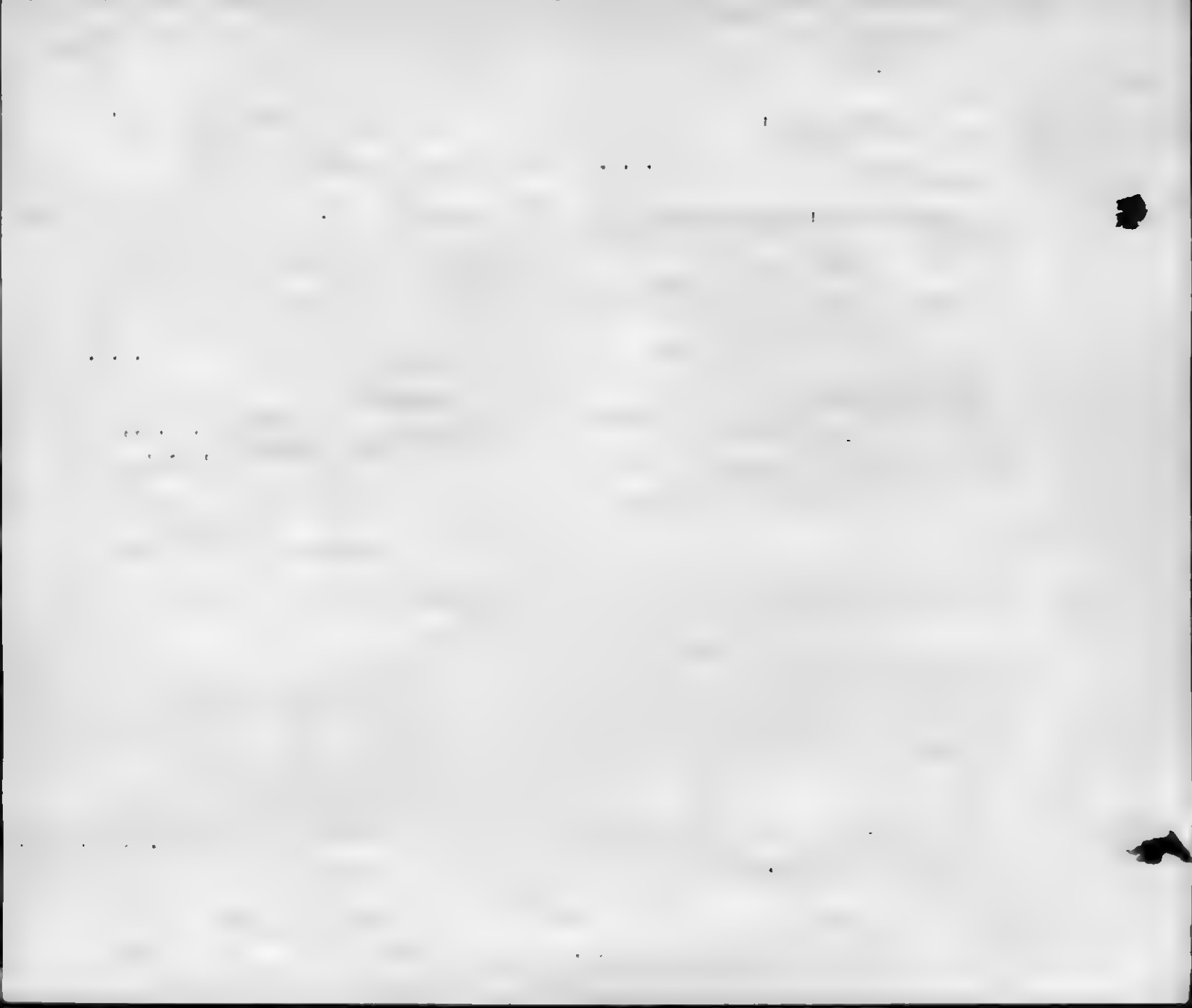
1011

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1003

1. PLACE OF DEATH a. COUNTY Prince George's		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN IL D.O.A.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince George's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Dupont Heights		d. STREET ADDRESS 4420 Shaw Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		NAME OF DECEASED (Type or print) Evelyn		First Middle Last GANTT		4. DATE OF DEATH Month Day Year January 14 19 61		9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.							
5 SEX Female		6 COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. C. TIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Asbury Jackson		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT William Gantt (Son)		917 45th St. N.E., Washington, D.C.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.																			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE James I. Boyd				EXAMINER'S NAME (Type) JAMES I. BOYD				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED Jan. 14th. 1961				Address (Street, city, town, or county)															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/18/61		22c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial				22d. LOCATION (City, town, or country) (State) Suitland, Maryland									
23. FUNERAL DIRECTOR Blues, Suitland				ADDRESS 30 H Street, N.E.				24a. REC'D BY REG STRAR DATE JAN 17 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Hines							

MEDICAL CERTIFICATION



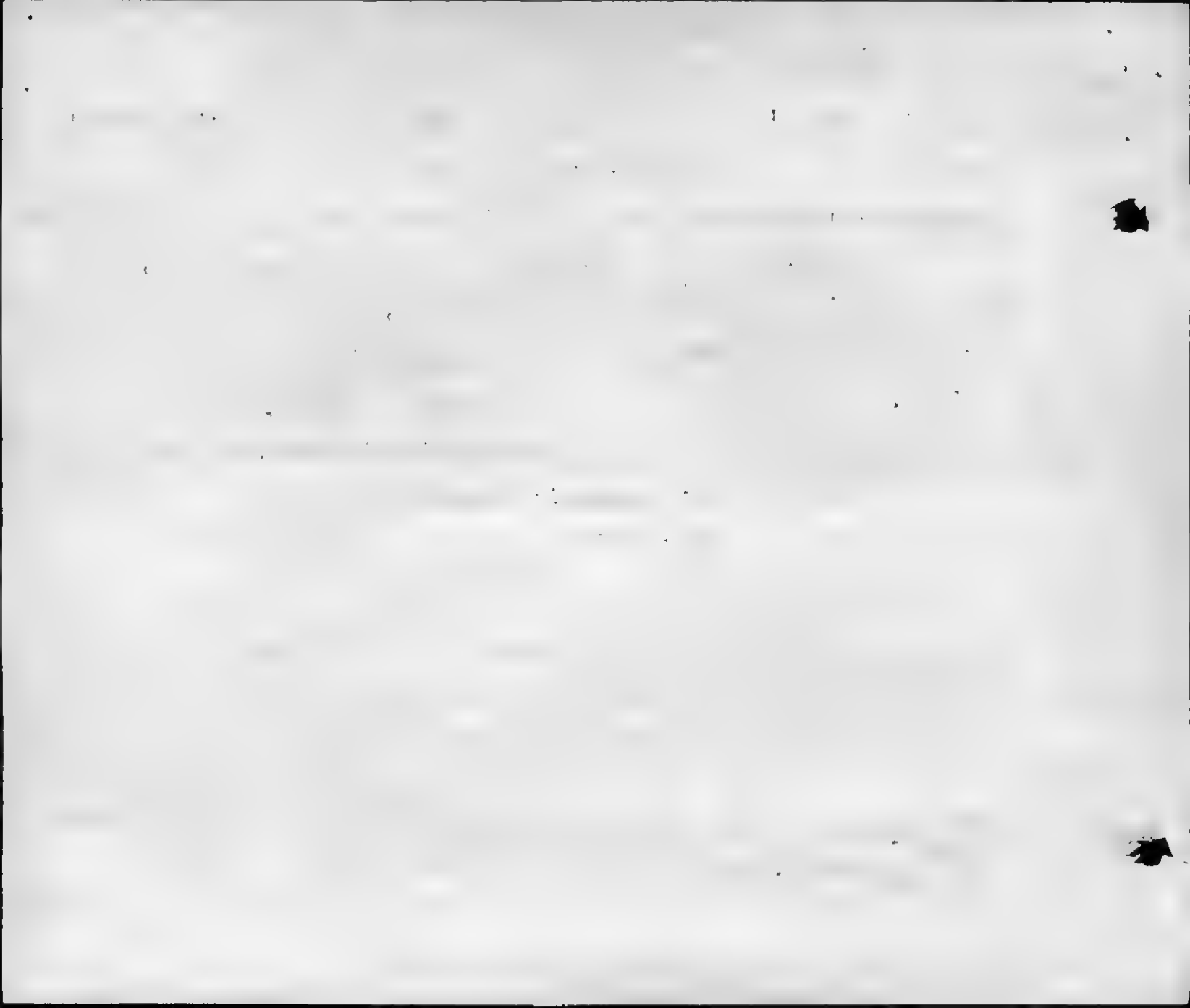
1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the health director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1012 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

61064

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East Pines	
c. LENGTH OF STAY IN 1b Dead on arrival		d. STREET ADDRESS 5811 64th Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nathan Gordon	4. DATE OF DEATH January 19, 1961	5. SEX Male 6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH December 17, 1898	9. AGE (In years last birthday) 62 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender	
11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME LEWIS GORDON	
14. MOTHER'S MAIDEN NAME RABECKA SHERLIS	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs Viola Virginia Gordon, Same as # 2	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (b) Myocardosis (c) 422.2 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DATE SIGNED 1/20/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JAN. 23, 1961	22c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY	22d. LOCATION (City, town, or country) (State) WASHINGTON DC
23. FUNERAL DIRECTOR B. Dargatzis & Sons ADDRESS 3501-14th NW.		24a. REC'D BY REGISTRAR JAN 25 '61 24b. REGISTRAR'S SIGNATURE Charles E. Kraus	



UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10065

1013

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs				c. LENGTH OF STAY IN lb 1 1/2 days			
d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Andrews AFB Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. 4771			
f. STREET ADDRESS 4669 Benning Rd, S.E.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Robert NMN Green III				4. DATE OF DEATH Month Day Year Jan 23 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 21, 1961	
9. AGE (In years last birthday) yrs. 17		10. IF UNDER 1 YEAR Months 192		11. IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY None			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert Green III				14. MOTHER'S MAIDEN NAME Catherine M Siscoe			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Hospital Chart				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis, congenital 762.5 DUE TO Prematurity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 1 1/2 days 1 1/2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from 21 Jan, 1961, to 23 Jan, 1961, that (we) last saw the deceased alive on 23 Jan, 1961, and that death occurred at 2 AM, from the causes and on the date stated above.							
22a. SIGNATURE Nicholas P. Haritos M.D.				22b. DATE SIGNED 23 Jan 61			
22c. PHYSICIAN'S NAME (Type) NICHOLAS P HARITOS, CAPT USAF (MC) USAF HOSP, ANDREWS AFB, WASH 25 DC				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremated		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY D.C. Morgue		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
				DATE JAN 30 1961			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 2260

1014

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY PRINCE GEORGES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BRANDYWINE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Southern Maryland Hospital Center		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NELSON Ambrose Grimes		4. DATE OF DEATH Month Day Year JAN. 23 1961	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-1888
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gov. employee Oper. (U.S. Gov.)		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Warren Grimes	
14. MOTHER'S MAIDEN NAME Sarah Hyde		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO ---		17. INFORMANT Mrs. Edith M. Grimes Brandywine, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO (b) arteriosclerosis DUE TO (c) myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/23 , 19 61 , to 1/23 , 19 61 , that I last saw the deceased alive on 1/23 , 19 61 , and that death occurred at 10:53 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Alfred R. Lapin, M. D.		ADDRESS (Street, city or town, state) Clinton, Md. DATE SIGNED 1/23/61	
PHYSICIAN'S NAME (Type) Alfred R. Lapin, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/26/61	22c. NAME OF CEMETERY OR CREMATORY St. Paul's Cem.	22d. LOCATION (City, town, or county) (State) Baden, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Catherine Ross Upper Merion, Md.		24a. REC'D BY REGISTRAR FEB 14 '61 DATE	
		24b. REGISTRAR'S SIGNATURE Charles L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1015

Item 9 Film 0281 2-15-61 et

CERTIFICATE OF DEATH

61066

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2 USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE Md b. COUNTY Pr. Geo.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rivendale, Md.				c. LENGTH OF STAY IN lb 13 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eugene Leland Memorial				d. STREET ADDRESS 5100 Pierce St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosie A. Gross				4. DATE OF DEATH Month Day Year Jan 14 1961			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/18/86	
9. AGE (In years last birthday) 74 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Sam Hughes				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Hospital Records Address 4408 Queensbury Rd.			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thromboses 332x DUE TO Intoxic poisoning Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO Cerebral thromboses (c) DUE TO Cerebral thromboses						INTERVAL BETWEEN ONSET AND DEATH 130 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21 I certify that (I) (this hospital) attended the deceased from Jan 13, 1961, to Jan 14, 1961, that (I) (we) last saw the deceased alive on Jan 13, 1961, and that death occurred at 10 p.m. from the causes and on the date stated above.							
22a. SIGNATURE L. H. Miller M.D.				22b. DATE SIGNED 1-14-61		22c. PHYSICIAN'S NAME (Type) L. H. Miller M.D.	
22d. ADDRESS 1740 N. ...							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1-19-61		23c. NAME OF CEMETERY OR CREMATORY Carver Memorial		23d. LOCATION (City, town, or county) (State) Marshall Md	
24 FUNERAL DIRECTOR'S SIGNATURE Henry S. ...				ADDRESS 4935 ... Ave		25a REC'D BY REGISTRAR DATE JAN 19 '61	
				25b REGISTRAR'S SIGNATURE C. ...			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1016

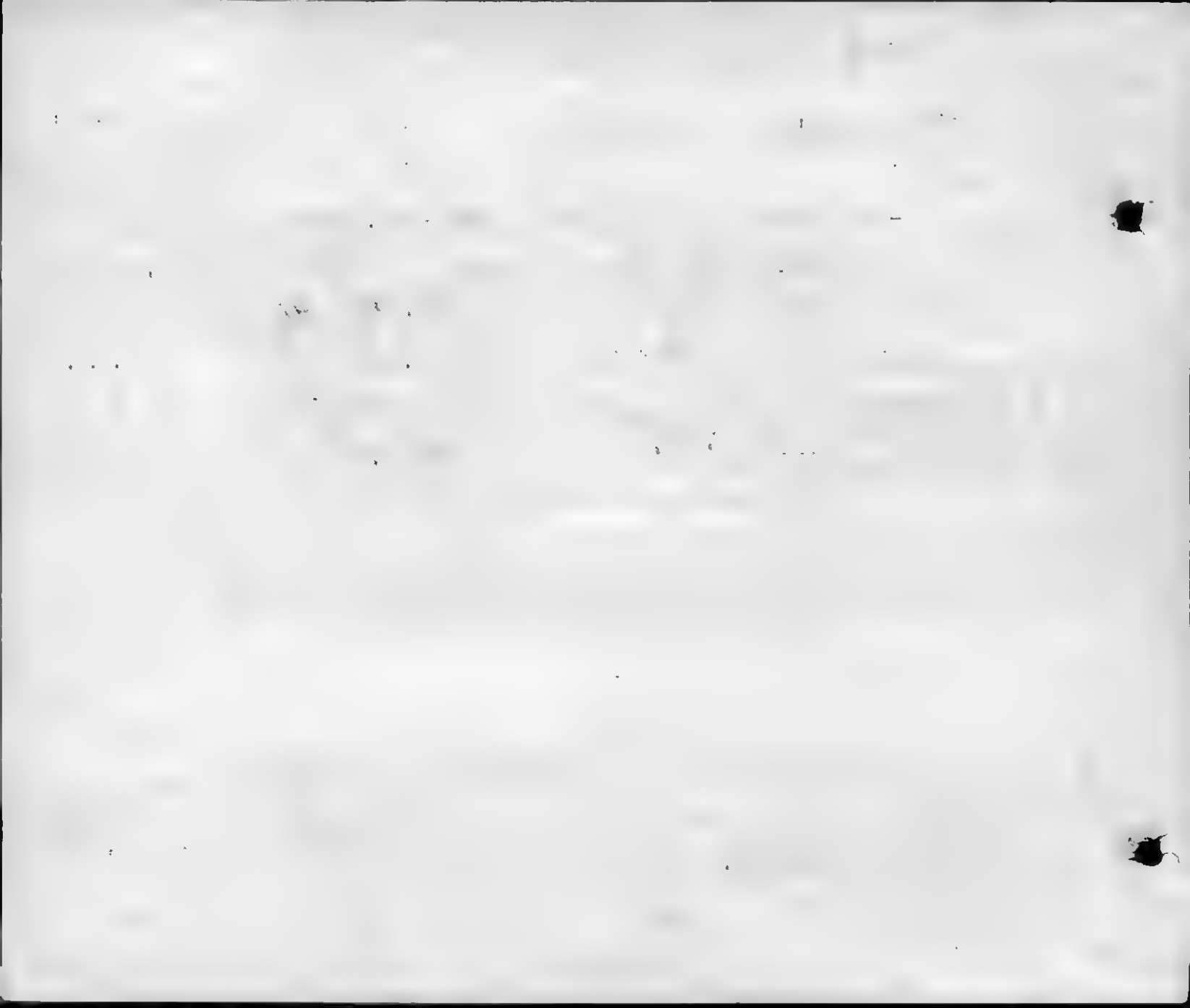
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

61067

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie c. LENGTH OF STAY IN b. 64 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) #19 - 9th Street		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bowie d. STREET ADDRESS #19 - 9th Street	
3. NAME OF DECEASED (Type or print) HAROLD RICHARD GRUBER		4. DATE OF DEATH Month Jan Day 21 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 24 1913	
9. AGE (In years last birthday) 47		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		10b. KIND OF BUSINESS OR INDUSTRY Entertainment	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Gruber		14. MOTHER'S MAIDEN NAME McKelvie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. YES	
17. INFORMANT Mrs Page Burgner		Address Same #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure 4422X DUE TO (b) Cardiovascular renal disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I Chronic pulmonary tuberculosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 24, 1961	
22c. NAME OF CEMETERY OR CREMATORY Alsace Cemetery		22d. LOCATION (City, town, or country) (State) Reading, Penna	
23. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale, Md		24a. REC'D BY REGISTRAR Arthur L. Kraus	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		DATE JAN 25 '61	

DATE SIGNED

Jan 21, 1961



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

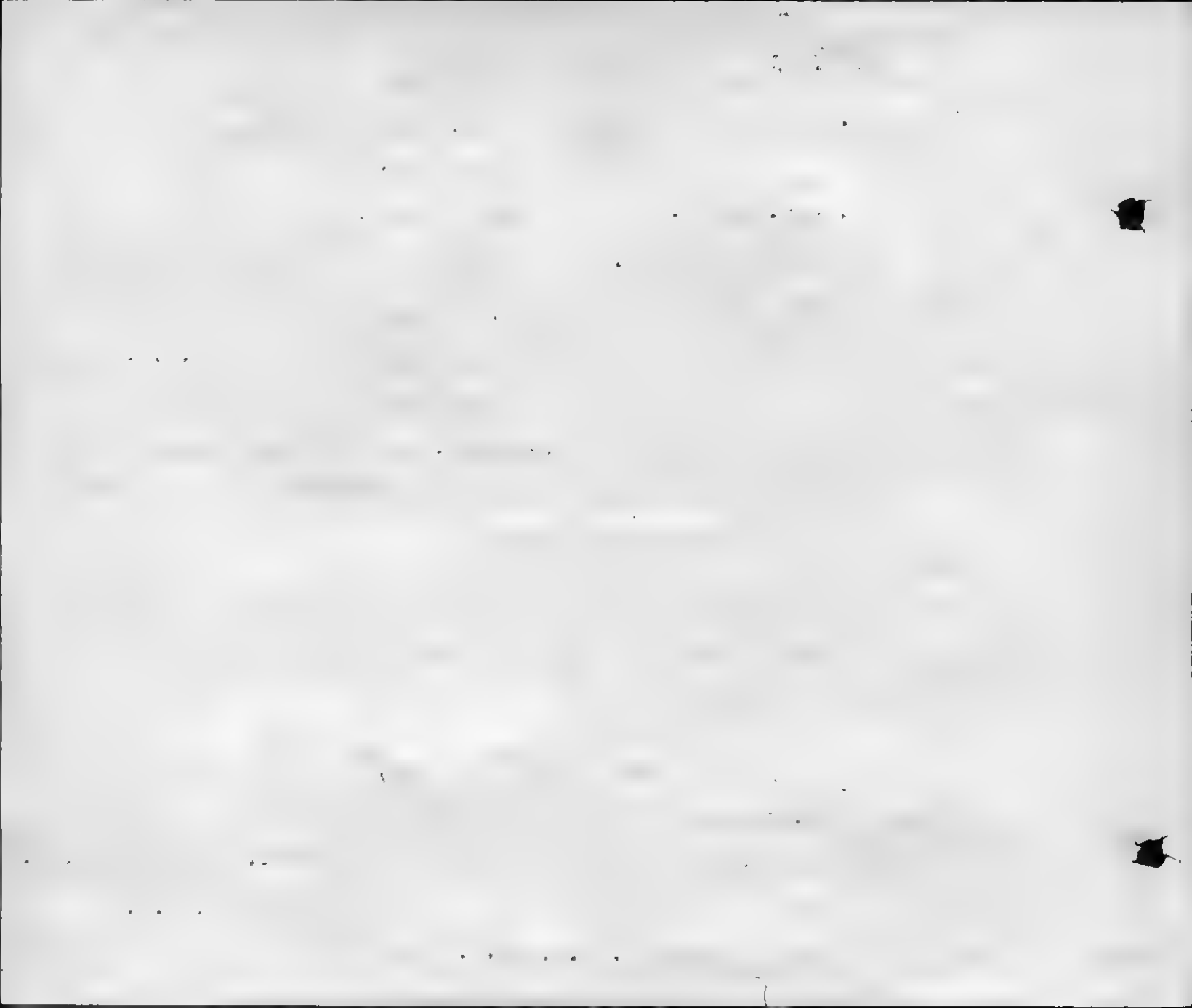
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1017
CERTIFICATE OF DEATH

61068

1. PLACE OF DEATH a. COUNTY Prince Geo. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 29 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Geo. Gen. Hos p.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Prince Geo. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly, d. STREET ADDRESS 2420- Lake Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frances First Middle H. Last Hall		4. DATE OF DEATH January 30 19 61 Month Day Year	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 19, 1889 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY New York	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Monty		14. MOTHER'S MAIDEN NAME Mary White	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No No unknown		17. INFORMANT Norman D. Hall Husband -same as above Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Cerebrovascular Accident My hypertension		INTERVAL BETWEEN ONSET AND DEATH 4 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Jan 1, 1960, to 1/30, 1961, that (I) (the) last saw the deceased alive on 1/30, 1961, and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Barry Rosenberg M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Barry Rosenberg		22d. ADDRESS 5102 Annapolis Rd. Bladensburg, Md.	
23a. BURIAL, CREMATION, REMOVAL, OR OTHER		23b. DATE THEREOF 2-2-61	
23c. NAME OF CEMETERY OR CREMATORY Riverside		23d. LOCATION (City, town or county) (State) Plattsburgh, N.Y.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4th St. N.E. D.C.		25a. REC'D BY REGISTRAR DATE FEB 2 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

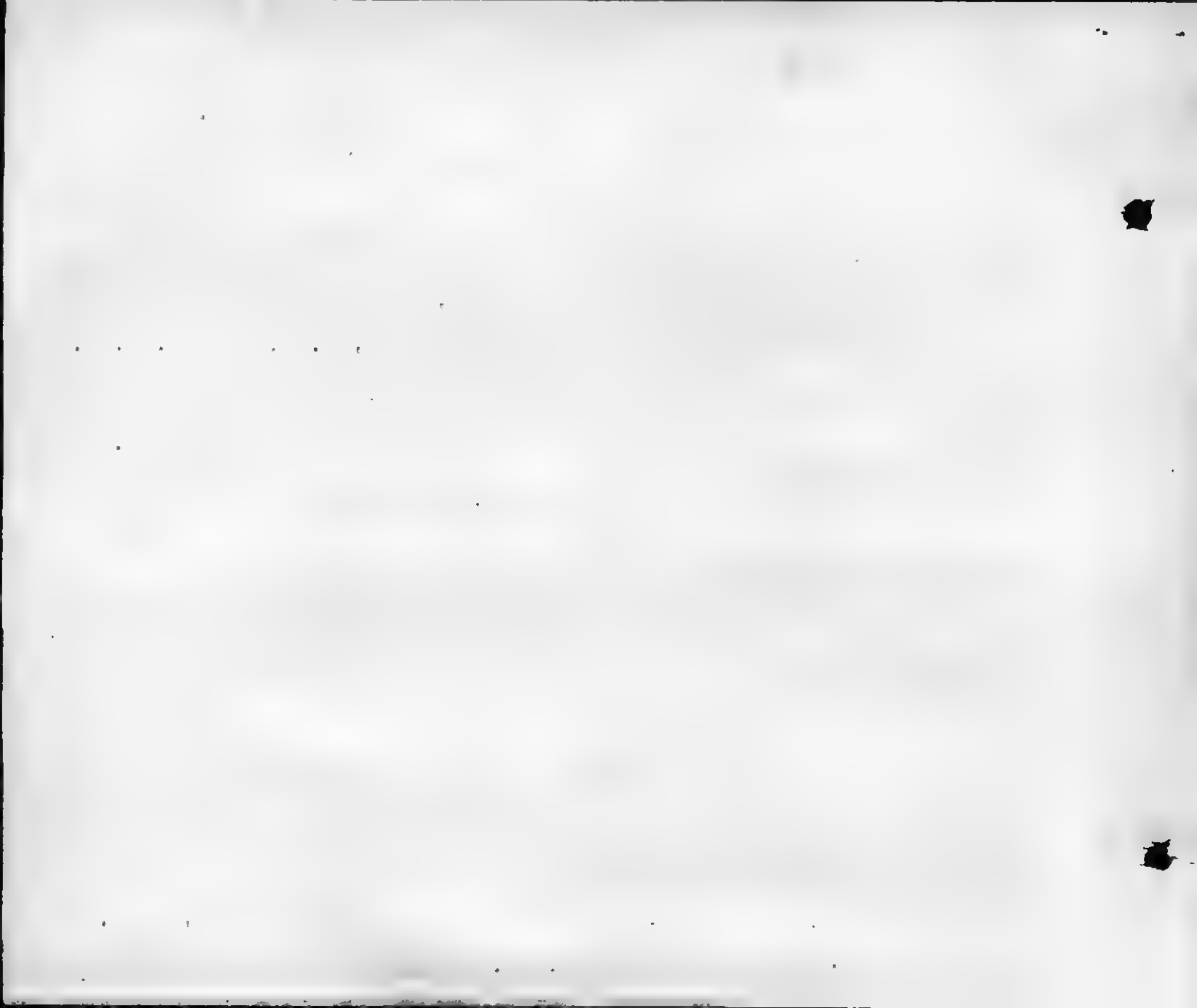
1018

61005

1 PLACE OF DEATH a. COUNTY Prince Georges B MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE Maryland b. COUNTY Pr. Geo's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Woodmore Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mitchellville	
3 NAME OF DECEASED (Type or print) First Middle Last Jesse Lee Hall Jr		4. DATE OF DEATH Month Day Year Jan 8 1961	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1928
9. AGE (In years last birthday) 32 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Instructor		10b. KIND OF BUSINESS OR INDUSTRY Own School	
11 BIRTHPLACE (State or foreign country) Washington, D. C.		12 CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jesse Lee Hall		14. MOTHER'S MAIDEN NAME Dorothy C. Waesche	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO	
17. INFORMANT Address Jesse Lee Hall- Same as Item #2.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 600.0 DUE TO Uterine (b) Pylonephritis (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Several years 32 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1957 to 1/8 1961, that I last saw the deceased alive on 1/7 1961, and that death occurred at 1:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. James Kurtz M.D.		ADDRESS (Street, city or town, state) RFD Bowie Md	
PHYSICIAN'S NAME (Type) H. James Kurtz		DATE SIGNED 1/8/61	
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/10/61	
22c. NAME OF CEMETERY OR CREMATORY Mt. Oak Cemetery		22d. LOCATION (City, town, or county) (State) Mitchellville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Upper Ritchie Bros. Fun'l Home-Marlboro, Md.		24a. REC'D BY REGISTRAR DATE JAN 16 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 Item 2 Film G280 2-6-61 et 1019 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH Reg. Dist. No. 1010

1019

CERTIFICATE OF DEATH

Reg. Dist. No.

1010

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland D.C.</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>				c. LENGTH OF STAY IN 1b <u>1 year</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Carroll Manor</u>				d. STREET ADDRESS <u>1867 Wyoming Ave.</u> <u>LASALLE ROAD / 1149222</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE M HALL</u>				4. DATE OF DEATH Month Day Year <u>1 28 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 23, 1875</u>	
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Cross</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Andrews</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Mrs. Sanford B. Leach-1608 44th St., NW</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Constrictive heart failure.</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiomyopathy</u> DUE TO <u>4 years</u>							
(c) <u>Hypertensive arteriosclerosis</u> DUE TO <u>4 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cometosis - several months before death</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1958</u> to <u>Jan 1961</u> , that I last saw the deceased alive on <u>Jan 21</u> , 19 <u>61</u> , and that death occurred at <u>3:30 p. m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4323 HAROLD ST SILVER SPRING, MD</u> DATE SIGNED <u>Richard P. Delaney</u>							
ACTUAL SIGNATURE <u>Richard P. Delaney</u> M.D. <u>4323 HAROLD ST SILVER SPRING, MD</u>							
PHYSICIAN'S NAME (Type) <u>RICHARD P. DELANEY MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-31-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>	
22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>James T. Ryan, Inc.</u>				ADDRESS <u>317 Pa. Ave., SE DC3</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 31 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1020

(1011)

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park Md				c. LENGTH OF STAY IN TB 3 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4113 Woodberry Street-				e. STREET ADDRESS 4113 Woodberry St			
3. NAME OF DECEASED (Type or print) First Vera Middle Millicent Last Hammond				4. DATE OF DEATH Month January Day 23 Year 1961-			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 23, 1888	
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Henry Howard Stephens				14. MOTHER'S MAIDEN NAME Williamina Fleming			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT Mildred H Speicher				Address University Park, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 428.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Coronary Artery Disease DUE TO (c) Generalized Arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July , 19 59 to Jan 14 , 19 61 , that I last saw the deceased alive on Jan 14 , 19 61 , and that death occurred at M , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Baltimore, Maryland							
DATE SIGNED 1-23-61							
ACTUAL SIGNATURE Richard L. Whelton							
PHYSICIAN'S NAME (Type) Richard L. Whelton							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF Jan 25, 1961							
22c. NAME OF CEMETERY Loudon Park Cemetery							
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons							
ADDRESS Hyattsville, Maryland							
24a. REC'D BY REGISTRAR DATE JAN 26 '61							
24b. REGISTRAR'S SIGNATURE L. J. S. Kenna							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



1021

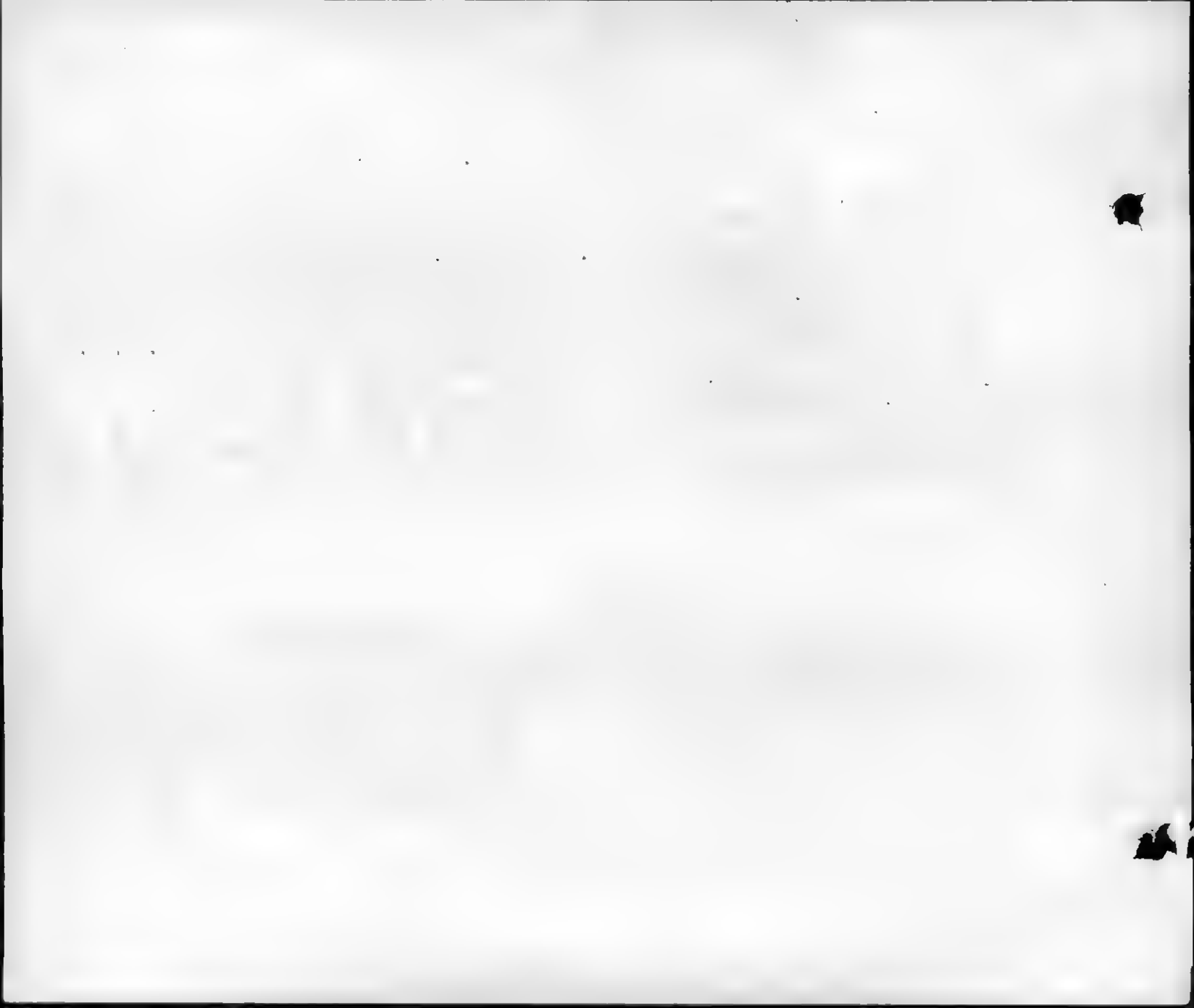
Item 11 File 6200 2-3-61 at

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

(1012)

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 24 Days		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1 Brandy wine	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				d. STREET ADDRESS Box 283		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle E. Last Hawkins		4. DATE OF DEATH Month January Day 28 Year 19 61		5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10/1/06		9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 10 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Pri. Geo. Co., Md.		11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bernino E. Hawkins		14. MOTHER'S MAIDEN NAME Helenetta Holladay		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. James R. Hawkins's Taylor Md	
17. INFORMANT James R. Hawkins's Taylor Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151 X DUE TO Suppurative peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Propped to the stomach DUE TO Propped to the stomach (c) Propped to the stomach		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 6	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 1/4 1961, to 1/28 1961, that (I) (we) last saw the deceased alive on 1/28 1961, and that death occurred at 9:07 from the causes and on the date stated above.		22a. SIGNATURE Wm. A. Holbrook M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE 1/29/61	
22c. PHYSICIAN'S NAME (Type) Wm. A. Holbrook		22d. ADDRESS 4500 College Ave., College Park, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-31-61	
23c. NAME OF CEMETERY OR CREMATORY St. Thomas		23d. LOCATION (City, town, or county) (State) Washington D.C.		24. FUNERAL DIRECTOR'S SIGNATURE George S. Holbrook ADDRESS Washington D.C.		25a. REC'D BY REGISTRAR JAN 30 '61 25b. REGISTRAR'S SIGNATURE Wm. S. Taylor	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1022
CERTIFICATE OF DEATH

1013

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md. c. LENGTH OF STAY IN 1b 30 min.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Prince George c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) University Park d. STREET ADDRESS 6603 Wells Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) ISABEL First Middle Last HAYES				4. DATE OF DEATH Month Day Year January 5 1961											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/4/77		9. AGE (in years lost birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY ---				11. BIRTHPLACE (State or foreign country) HARTWICH, N. Y.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME MENZO INGALLS				14. MOTHER'S MAIDEN NAME LUCENDA ROBINSON											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---				17. INFORMANT HOSPITAL RECORDS Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema. Bilateral Hydrothorax 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial Fibrosis DUE TO (c) Coronary Arteriosclerotic Heart Disease DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 hours years years												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Jan 5 1961		(County) Jan 5 1961		(State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 5 1961 to Jan 5 1961 , that (I) (we) last saw the deceased alive on Jan 5 1961 , and that death occurred at 4:15 p.m. from the causes and on the date stated above.															
22a. SIGNATURE Benjamin S. Miller				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type or print) BENJAMIN S. MILLER, M. D.				22d. ADDRESS PRINCE GEORGES COUNTY, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL-REMOVAL				23b. DATE THEREOF HARTWICK SEMINARY				23c. NAME OF CEMETERY OR CREMATORY COOPERSTOWN, N. Y.				23d. LOCATION (City, town, or county) (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Joseph Ben-Lissano				ADDRESS 1756 E. 11th St.				25a. REC'D BY REGISTRAR JAN 9 '61				25b. REGISTRAR'S SIGNATURE Charles E. Kline			

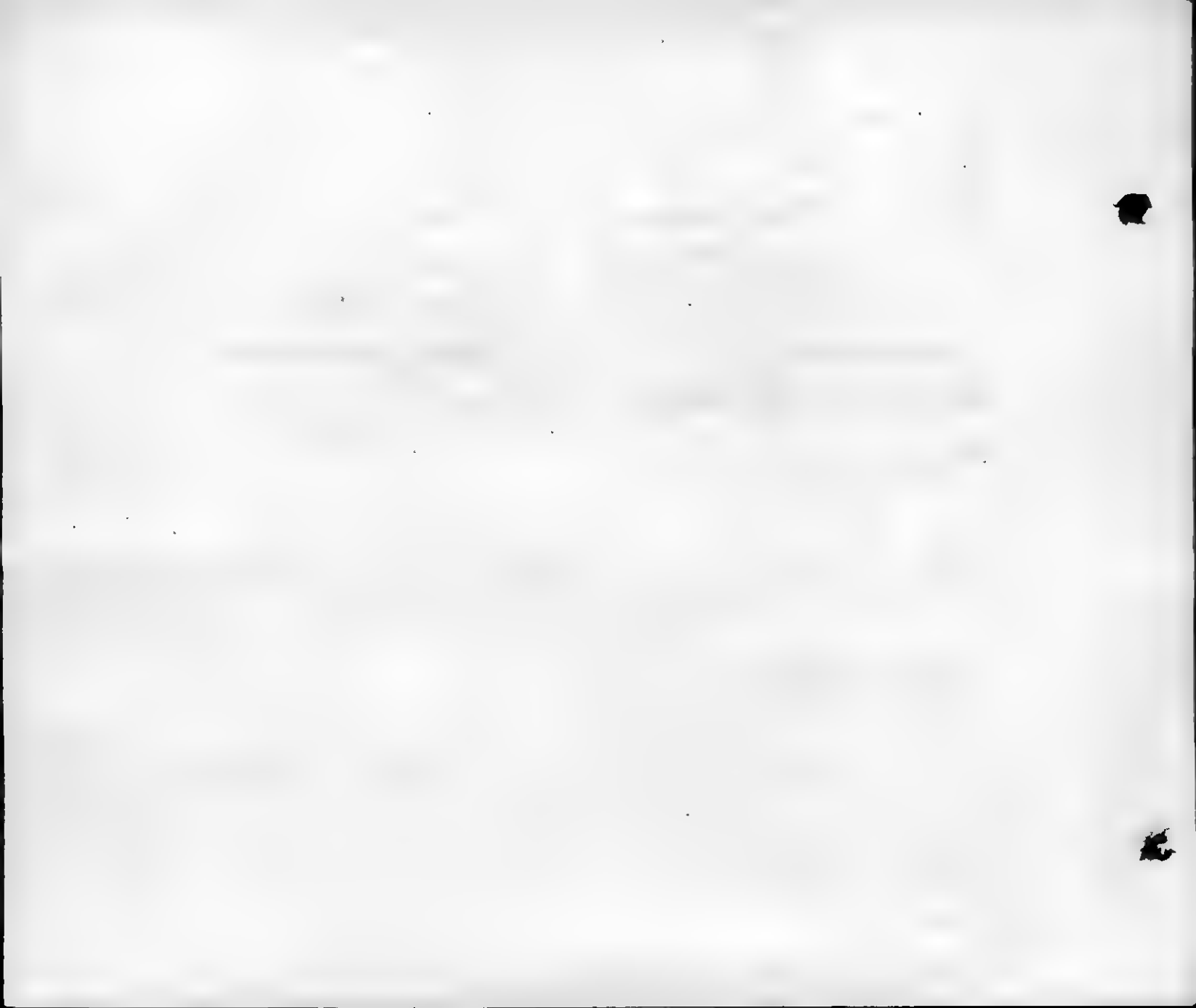


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1023 CERTIFICATE OF DEATH

61014

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Mont.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel - Adelphi				c. LENGTH OF STAY IN 1b 3 3/4 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Saint Branch Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anne Morrison Hookman				4. DATE OF DEATH 1 - 22 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1866	9. AGE (In years lost birthday) 94 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Nova Scotia, Canada	
12. CITIZEN OF WHAT COUNTRY? U. S. F.				13. FATHER'S NAME Archibald McKinnon			
14. MOTHER'S MAIDEN NAME CATHERINE McFEE				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO				17. INFORMANT Mrs C. B Smith - (same as #1)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 1 wk 10 yrs 20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from July 1961 to Jan 22, 1961, that (I) (we) last saw the deceased alive on Jan 21, 1961, and that death occurred at 2:30 P. M. from the causes and on the date stated above.			
22a. SIGNATURE James N. Whitlock				22b. DATE SIGNED 1-22-61			
22c. PHYSICIAN'S NAME (Type or print) JAMES N. WHITLOCK				22d. ADDRESS Takoma Park Md			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Jan 26, 1961		23c. NAME OF CEMETERY OR CREMATORY EASTWOOD CEMETERY		23d. LOCATION (City, town, or county) (State) Lancaster, Mass.	
24. FUNERAL DIRECTOR'S SIGNATURE J. Arthur Walter				25a. REC'D BY REGISTRAR 254 Carroll St NW		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
DATE JAN 25 '61							



CERTIFICATE OF DEATH

Reg. Dist. No. (101)

1024

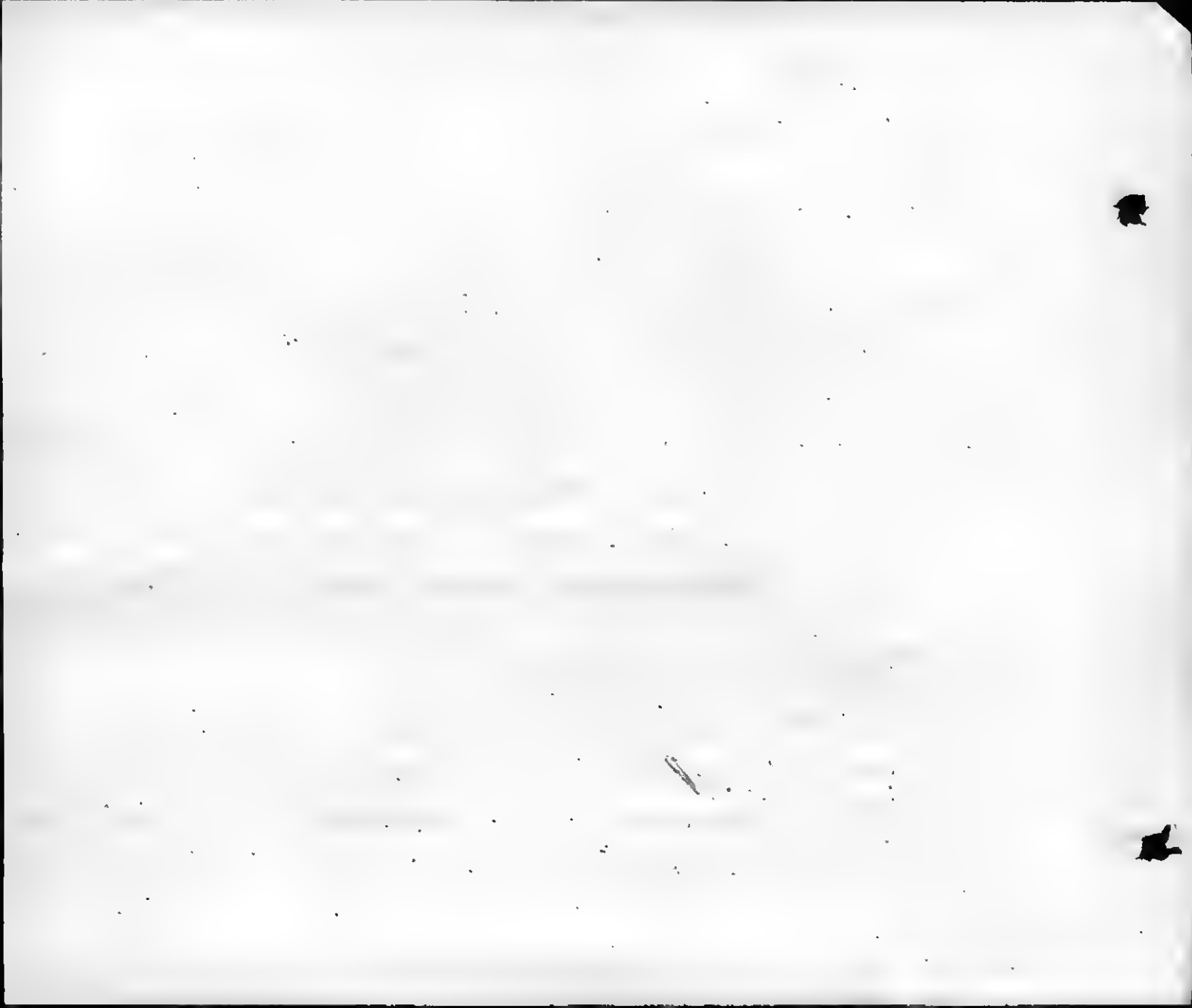
1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SOUTHERN MD. HOSP. CENTER		e. STREET ADDRESS 642 95th S.E.	
3. NAME OF DECEASED (Type or print) First Middle Last Helen Veronica Heller		4. DATE OF DEATH Month Day Year JAN. 4 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/1898
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) WASH. D.C.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME William Brown		14. MOTHER'S MAIDEN NAME MARY ANNE WEISALLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) N/C		16. SOCIAL SECURITY NO. 57F-26-2022	
17. INFORMANT (SON)		Address RT 2 BX 382 CLINTON, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) RESPIRATORY FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 443X (b) LEFT CEREBRO-VASCULAR ACCIDENT (c) HYPERTENSIVE ARTERIOSCLEROTIC CV DISEASE		INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES 36 HRS. 15 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NONE		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) NONE	
20c. TIME OF INJURY Month, Day, Year Hour, m., p. NONE		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> NONE	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) NONE		20f. (City or town) (County) (State) NONE	
21. I certify that I attended the deceased from 12/23, 1960 to Present , that I last saw the deceased alive on Jan. 4, 1961 , and that death occurred at 1:15 P.M. from the causes and on the date stated above			
ACTUAL SIGNATURE Arthur Shaver Jr. M.D.		ADDRESS (Street, city or town, state) BRANCH AVE. CLINTON MD. DATE SIGNED 1/4/61	
PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. M.D. BRANCH AVE. CLINTON, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/7/61	22c. NAME OF CEMETERY OR CREMATORY WASH-NOTE Com	22d. LOCATION (City, town, or county) (State) SUITLAND B-R 6600 MD
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Chambers Co. ADDRESS 577 11th St SE		24a. REC'D BY REGISTRAR DATE JAN 9 '61	24b. REGISTRAR'S SIGNATURE C. W. S. Thomas

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

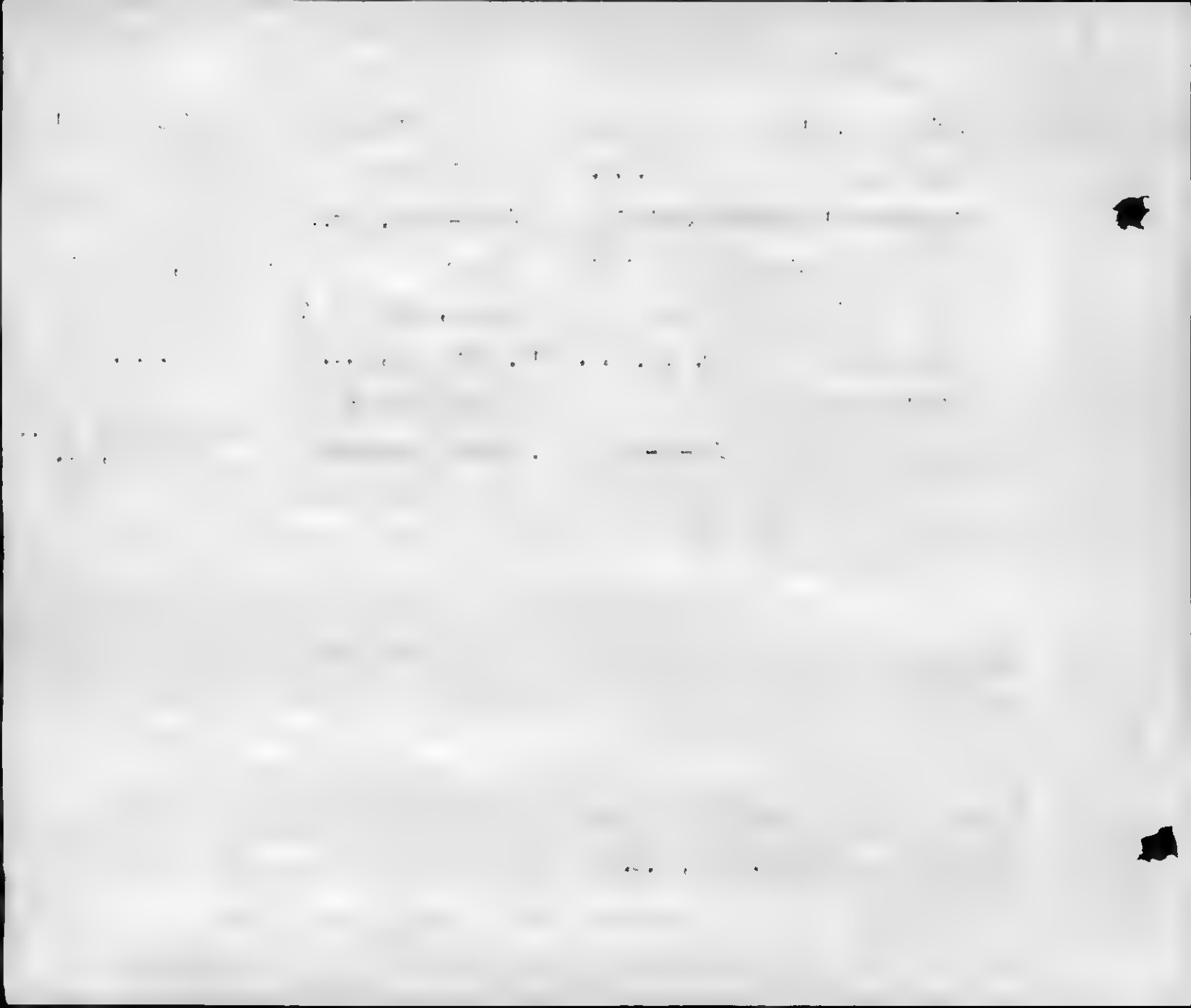
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1025 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1016											
1. PLACE OF DEATH a. COUNTY Prince George's						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg d. STREET ADDRESS 4102 - 53rd. Ave.,					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly						c. LENGTH OF STAY IN 1b D.O.A.					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) William Christian Heller						4. DATE OF DEATH Jan. 4, 1961 Month Day Year					
5. SEX Male						6. COLOR OR RACE White					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH May 19, 1884 Last First Middle					
9. AGE (In years last birthday) 76 yrs.						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner						10b. KIND OF BUSINESS OR INDUSTRY Bur. Eng. U.S.GOV'T.					
11. BIRTHPLACE (State or foreign country) Brooklyn, N.Y.						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME William Heller						14. MOTHER'S MAIDEN NAME Elise Eberly					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO						16. SOCIAL SECURITY NO. 579-38-7879					
17. INFORMANT Mr. Richard Sparrough						Address 2813 Cheverly Ave., Cheverly, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 Conditions, any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) Coronary Arteriosclerosis Cardiovascular renal disease						INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED Jan 4, 1961					
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify)						22b. DATE THEREOF Jan. 7, 1961					
22c. NAME OF CEMETERY OR CREMATORY Stenwood Cem.						22d. LOCATION (City, town, or country) (State) Washington, D.C.					
23. FUNERAL DIRECTOR W. W. Chambers Co						24a. REC'D BY REGISTRAR Riverdale, Md.					
24b. REGISTRAR'S SIGNATURE Arthur L. Kline						DATE JAN 9 '61					

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

JAMES I. BOYD, M.D.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any part of this certificate is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2159

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1026 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02220

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro Md</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upper Marlboro</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Old Cabin Highway</u>				d. STREET ADDRESS <u>Old Cabin Highway</u>			
3. NAME OF DECEASED (Type or print) <u>Male</u> First <u>Swaneta</u> Middle <u>Halmer</u> Last <u>Halmer</u>				4. DATE OF DEATH <u>January 28</u> 19 <u>61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 9, 1960</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vincent T. Halmer</u>				14. MOTHER'S MAIDEN NAME <u>Clara Hamilton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no) or unknown (If yes give year or dates of service) <u>none</u>				16. SOCIAL SECURITY NO <u>none</u>			
17. INFORMANT <u>Mrs Clara Halmer, son-in-law #2</u>				Address <u>none</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>493X</u> DUE TO <u>Pneumonia</u> (c) <u>493X</u> DUE TO <u>Pneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James I. Boyd</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/30/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>				22d. LOCATION (City, town, or country) (State) <u>Upper Marlboro, Md.</u>			
23. FUNERAL DIRECTOR <u>Ritchie Bros. Fun'l Home - Marlboro, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 14 61</u>			
ADDRESS <u>Upper</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

17241



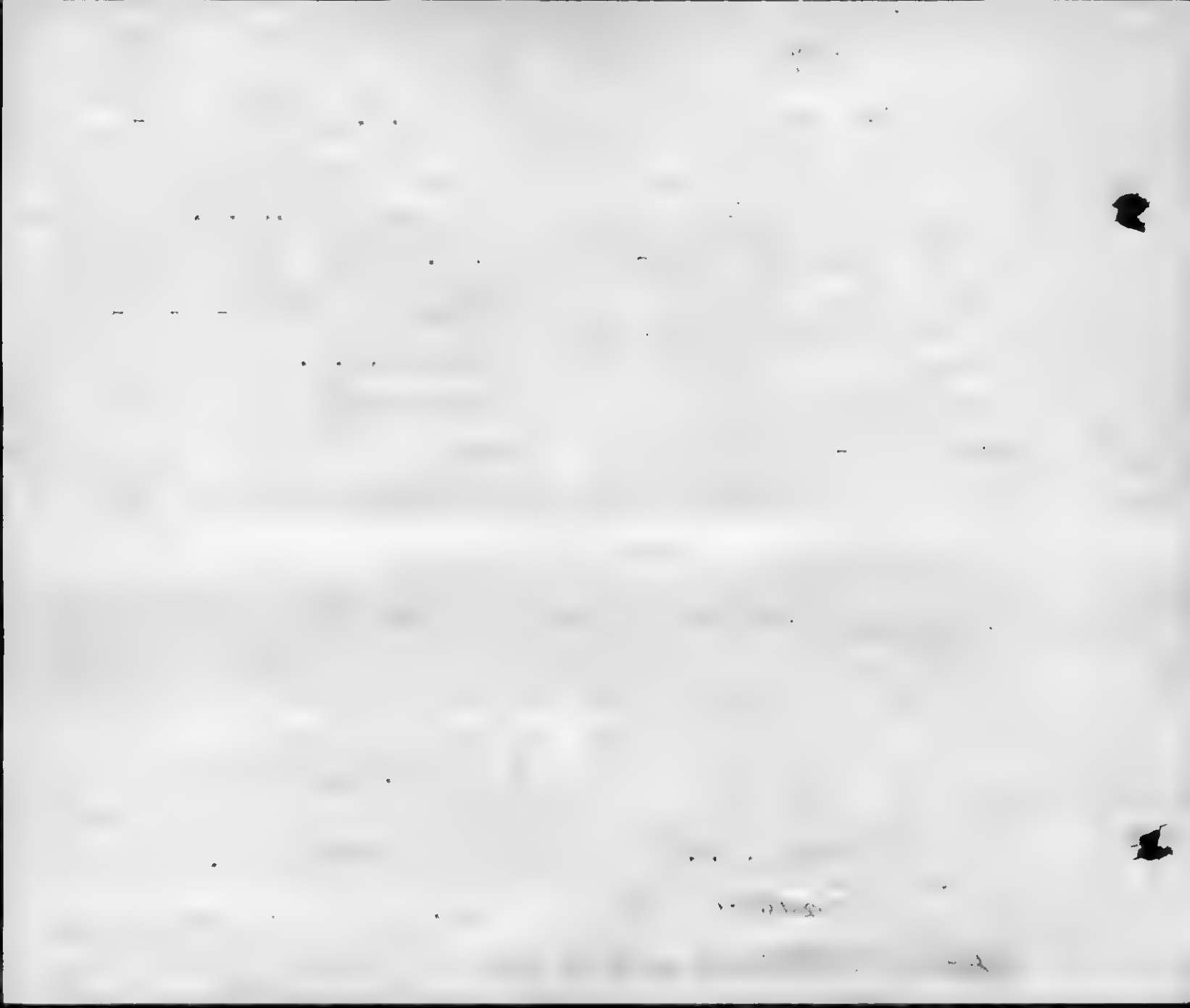
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1027

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Glenn Dale (rural) c. LENGTH OF STAY N 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Glenn Dale Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D. C. b. COUNTY c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 665 24th St., N. E.	
3. NAME OF DECEASED (Type or print) John First Middle Last 4. DATE OF DEATH 1 23 19 61 Month Day Year		5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 8/3/1884 yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY Capital Transit Company 11. BIRTHPLACE (County & State, or foreign country) Washington, D. C. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John Holmes 14. MOTHER'S MAIDEN NAME Martha Johnson 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Decedent Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic pyelonephritis with renal failure DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). Diabetes mellitus, uncontrolled; arteriosclerotic heart disease; left inguinal hernia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 6/15/60 9:25 P.M. to 1/23/1961 that (I) (we) last saw the deceased alive on 1/23/1961, and that death occurred at A.M. from the causes and on the date stated above.	
22a. SIGNATURE Moe Weiss 22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22b. DATE SIGNED 1/23/61 22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.	
23. BURIAL OR CREMATION, 23b. DATE THEREOF 1/28/61 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Ceme.		23d. LOCATION (City, town or county) Suitland, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE John S. Stewart, 30 H St. NE ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 25 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

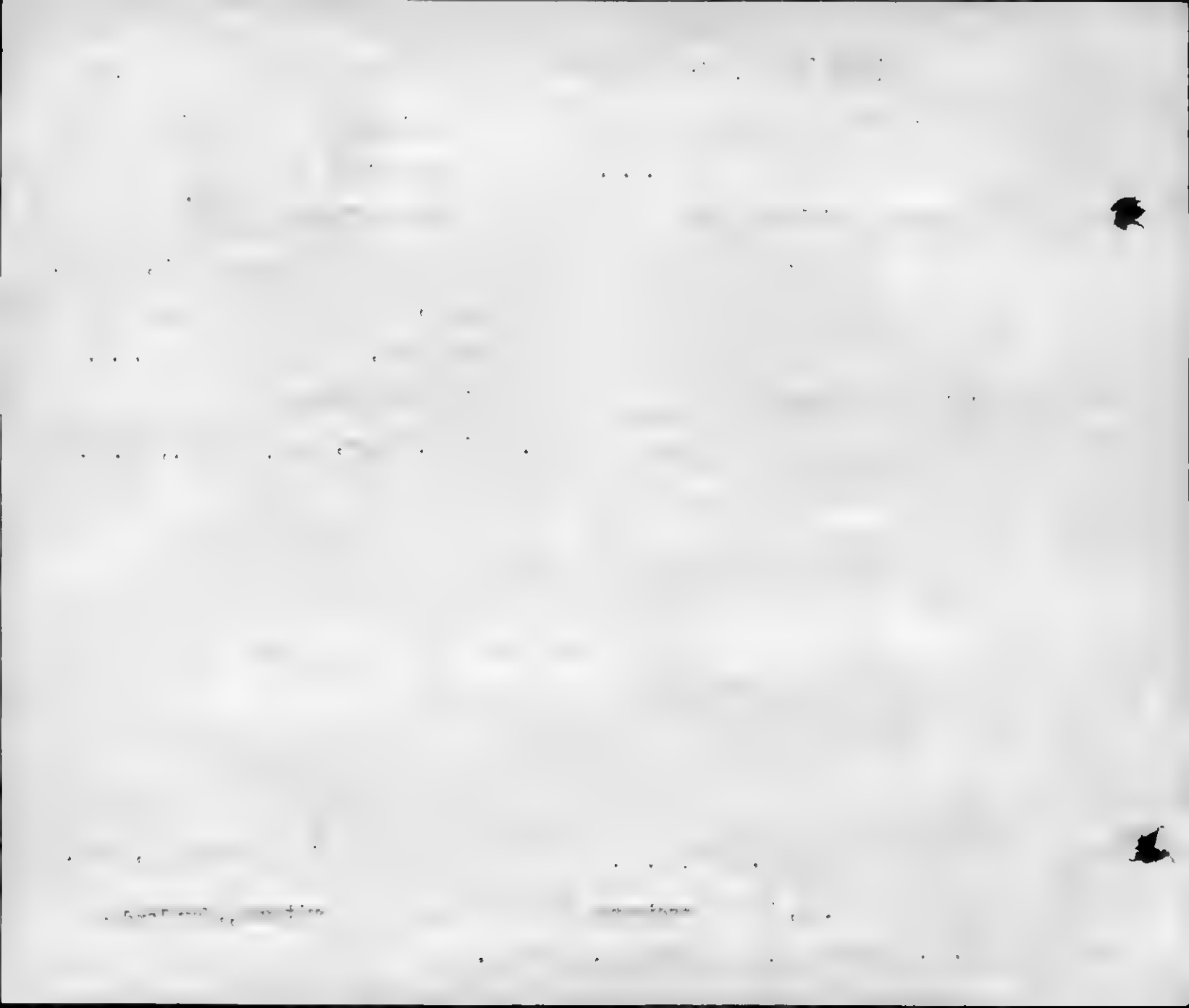


1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
1028 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Prince Georges County						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hyattsville d. STREET ADDRESS 3607 Longfellow Street					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Riverdale						c. LENGTH OF STAY IN 1b D.O.A.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Leland Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) DAVID CLINTON HONEA						4. DATE OF DEATH Month January Day 28 Year 1961					
5. SEX Male						6. COLOR OR RACE White					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>						8. DATE OF BIRTH December 9, 1954					
9. AGE (In years last birthday) 6 yrs.						10. IF UNDER 1 YEAR Months 28 Days 28 Hours 1961					
11. BIRTHPLACE (State or foreign country) Takoma Park, Maryland						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Carl Edward Honea						14. MOTHER'S MAIDEN NAME Annie Juanita Breece					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. None					
17. INFORMANT Mrs. Annie J. Honea,						Address 3607 Longfellow St., Hyatts., Md. Apt. 5					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Carbon monoxide poisoning (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) occupant of an apartment that is for											
20c. TIME OF INJURY Month, Day, Year 1-28-1961											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home											
20f. (City or town) (County) (State) Hyattsville P.S. Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE James I. Boyd CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) JAMES I. BOYD, M. D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED January 29, 1961.											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
22b. DATE THEREOF Feb. 1, 1961											
22c. NAME OF CEMETERY OR CREMATORY Washington National Cemetery											
22d. LOCATION (City, town, or country) (State) Suitland, Maryland											
23. FUNERAL DIRECTOR W. W. CHAMBERS CO.,											
ADDRESS Riverdale, Maryland.											
24a. REC'D BY REGISTRAR JAN 31 '61											
24b. REGISTRAR'S SIGNATURE Arthur L. Hines											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The funeral director, the hospital or attending physician, or the funeral director, after this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 1 Film 270 1-11-61

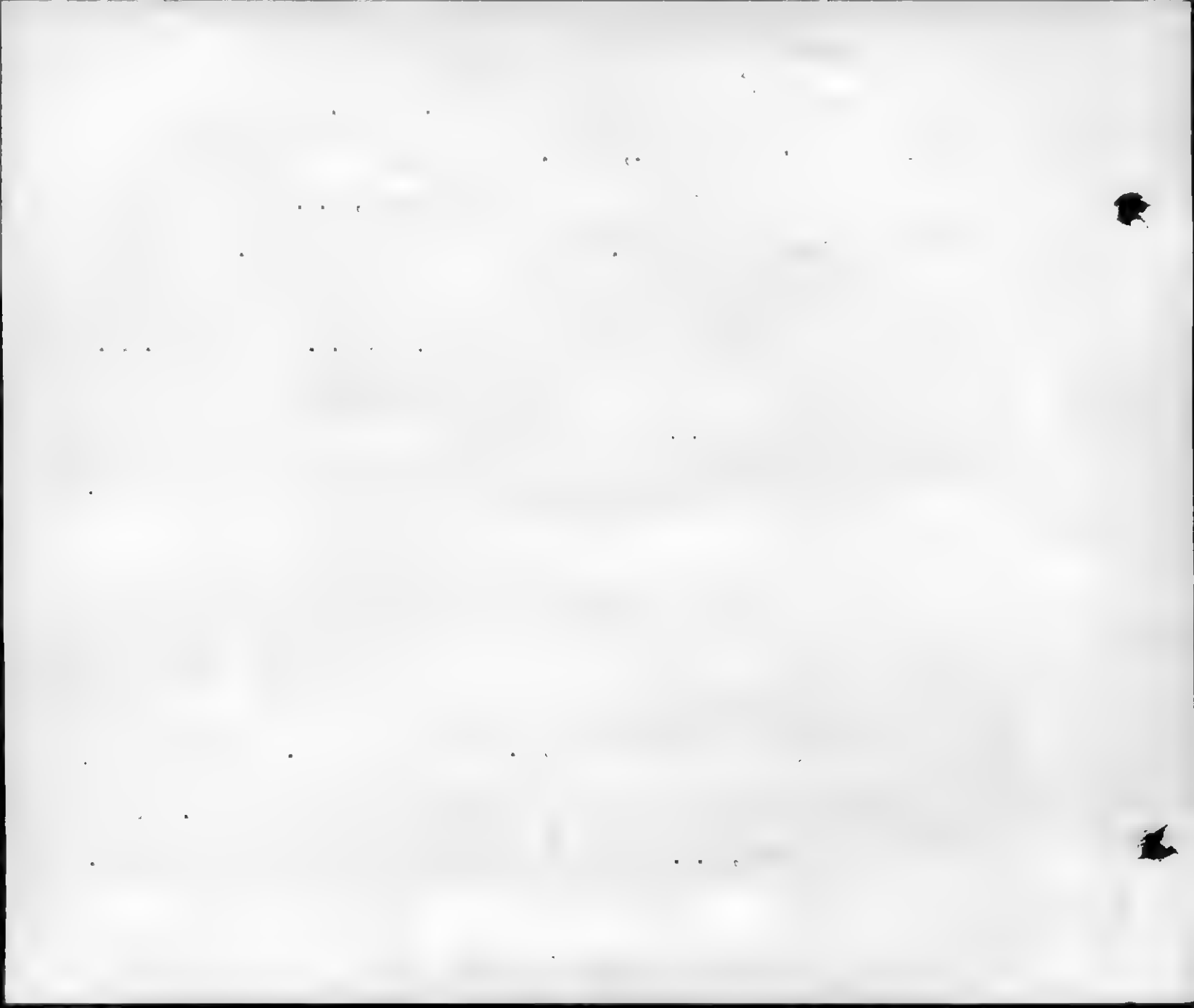
1029

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1019

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Dist. of Col. b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Glenn Dale				c. LENGTH OF STAY IN 1b 4 mo.; 9 das.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 2917 M Street, S.E.			
3. NAME OF DECEASED (Type or print) Michael First J. Middle Horan Last				4. DATE OF DEATH Jan. Month 14 Day 1961 Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6, 1895	
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME David Horan				14. MOTHER'S MAIDEN NAME Annie Moran			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) Yes WW I Army				16. SOCIAL SECURITY NO unknown		17. INFORMANT Decedent Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Adenocarcinoma of Right Lung with local and regional metastases DUE TO 153X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Pulmonary tuberculosis, active DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 11 mo. (by history)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a. m. 1 p. m. 1				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug. 5 1960 , to Jan. 14 1961 that (I) (we) last saw the deceased alive on Jan 14 1961 , and that death occurred at 4:00 PM , from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. DATE SIGNED Jan. 14, 1961			
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.				22d. ADDRESS Glenn Dale Hospital, Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 1/18/61		23c. NAME OF CEMETERY OR CREMATORY Arlington		23d. LOCATION (City, town, or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Timothy Naulon - 8831 - G.A. AVE				25a. REC'D BY REGISTRAR DATE JAN 19 '61		25b. REGISTRAR'S SIGNATURE C. L. R. R.	



MEDICAL CERTIFICATION

V5 A15 (4)
1SM 10/57

1018

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

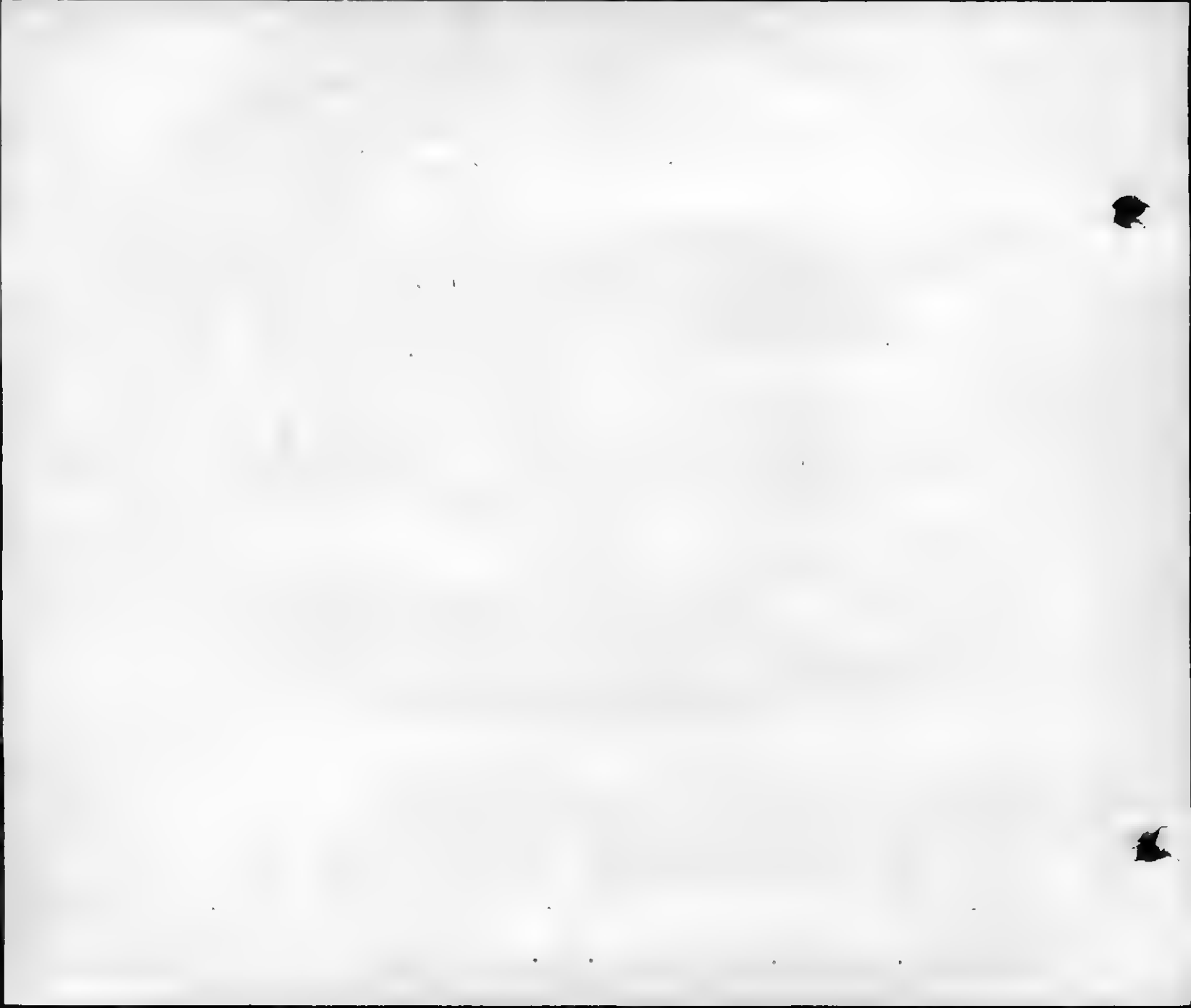
CERTIFICATE OF DEATH

61021

1031

Item 8-11-61-20-2-2-61-61

1. PLACE OF DEATH a. COUNTY Prince Geo. MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Geo			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park.				c. LENGTH OF STAY IN 1b 20 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 6428 Slig Mill Rd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Andrew Compton Hunt				4. DATE OF DEATH Month Day Year Jun 28 1961			
5. SEX M	6. COLOR OR RACE Wh	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/15/1888	9. AGE (In years last birthday) 72 yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY carpenter		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joseph (J) Hunt				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO				16. SOCIAL SECURITY NO. --		17. INFORMANT Son - Gen W. Hunt Sr - 1937 Howard St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma, common bile duct 15:11 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastasis. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec 7 1960 to Jan 28 1961, that (I) (we) last saw the deceased alive on Jan 28 1961, and that death occurred at 3 PM, from the causes and on the date stated above.							
22a. SIGNATURE William F. Simpson, Jr				22b. DATE SIGNED 1/28/61		22c. PHYSICIAN'S NAME (Type) William F. Simpson, Jr	
				22d. ADDRESS 6216 N H Ave NE			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		1-31-61		Cedar Hill Cemetery		Suitland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James T. Ryan, Inc.				ADDRESS 317 Pa. Ave., SE DC		25a. REC'D BY REGISTRAR DATE JAN 31 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Hunt			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1032

61022

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond Hill		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 8731- 113rd Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Josephine		First T Middle Hutchinson Last		4. DATE OF DEATH Month Jan Day 18 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 29 July 1883	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Jeremiah Costigan				14. MOTHER'S MAIDEN NAME Johannah Drennen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT John K Hutchison		Address Cheverly, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction DUE TO (b) congestive heart failure DUE TO (c) pleural effusion from metastatic Ca Conditions (if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH 1 hr. 3 days 2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/10, 1960 to 1/18, 1961 that (I) (we) last saw the deceased alive on 1/18, 1961 , and that death occurred at 1:10 AM from the causes and on the date stated above							
22a. SIGNATURE <i>[Signature]</i> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 1/18/61	
22c. PHYSICIAN'S NAME (Type) Dr. F. Musser., M.D.				22d. ADDRESS 4410 74th Ave., Beallmeade, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Transportation Jan 19, 1961		Richmond Hills		New York			
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland.		25a. RECEIVED BY REGISTRAR JAN 20 1961	
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

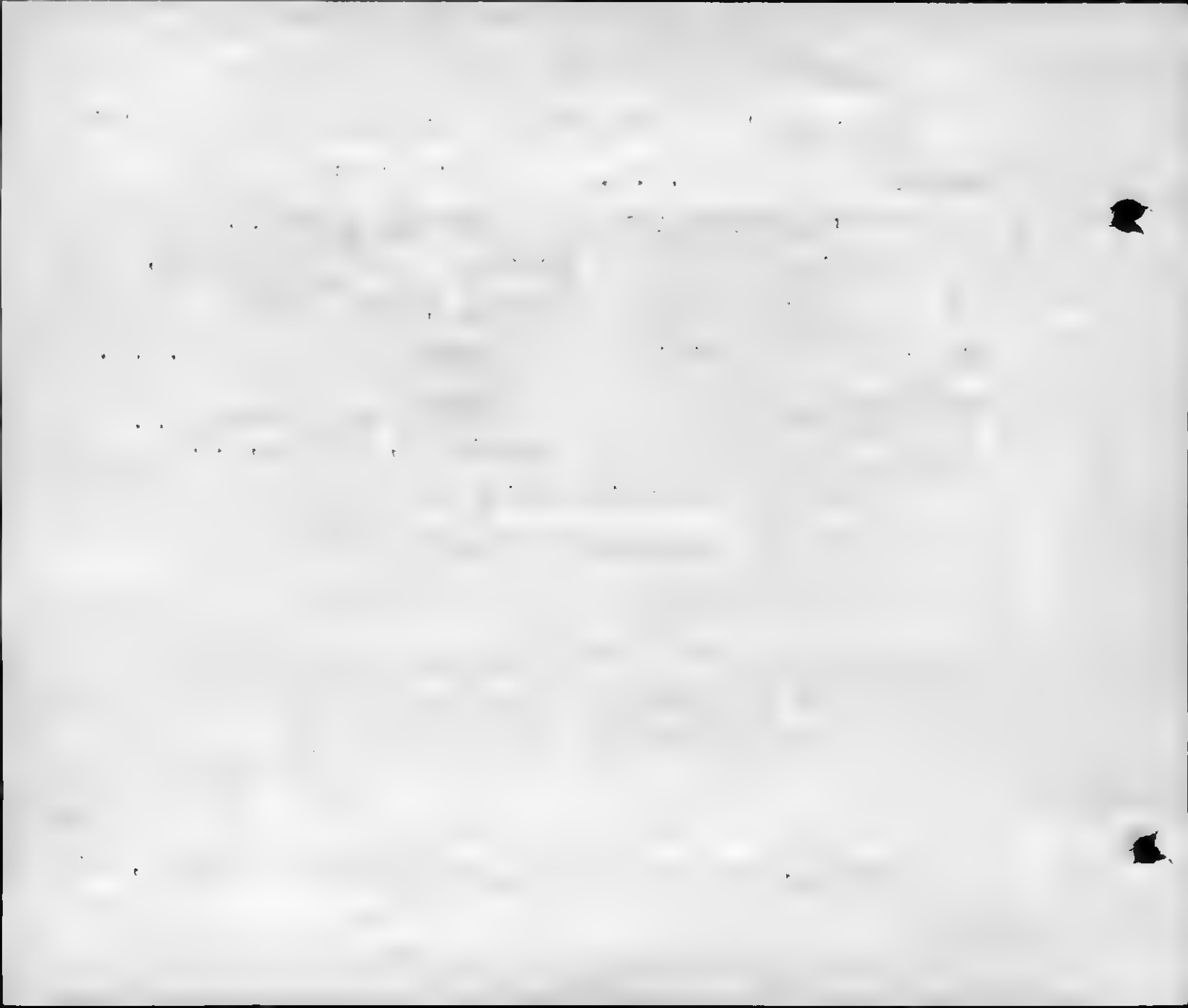
(1023)

1. PLACE OF DEATH a. COUNTY Prince George's		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b D. O. A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmont Heights	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 6006 Sheriff Road S.E.		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Henry Jackson		4. DATE OF DEATH January 31, 1961		5. SEX Male	
6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 4, 1884	
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason		11. BIRTHPLACE (State or foreign country) Georgia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Joshua Jackson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 308 11th Street S.E.		17. INFORMANT Madelain Kell, Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Obstructive Jaundice 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of the Stomach with Metastasis DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED January 31, 1961	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) 2-4-61		22b. DATE THEREOF 2-4-61		22c. NAME OF CEMETERY OR CREMATORY Nat. Harmony Park Highland Park Md	
22d. LOCATION (City, town, or county) 23. FUNERAL DIRECTOR H S Washington 4925 Deane Ave NE		22e. ADDRESS 24a. REC'D BY REGISTRAR DATE FEB 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☐



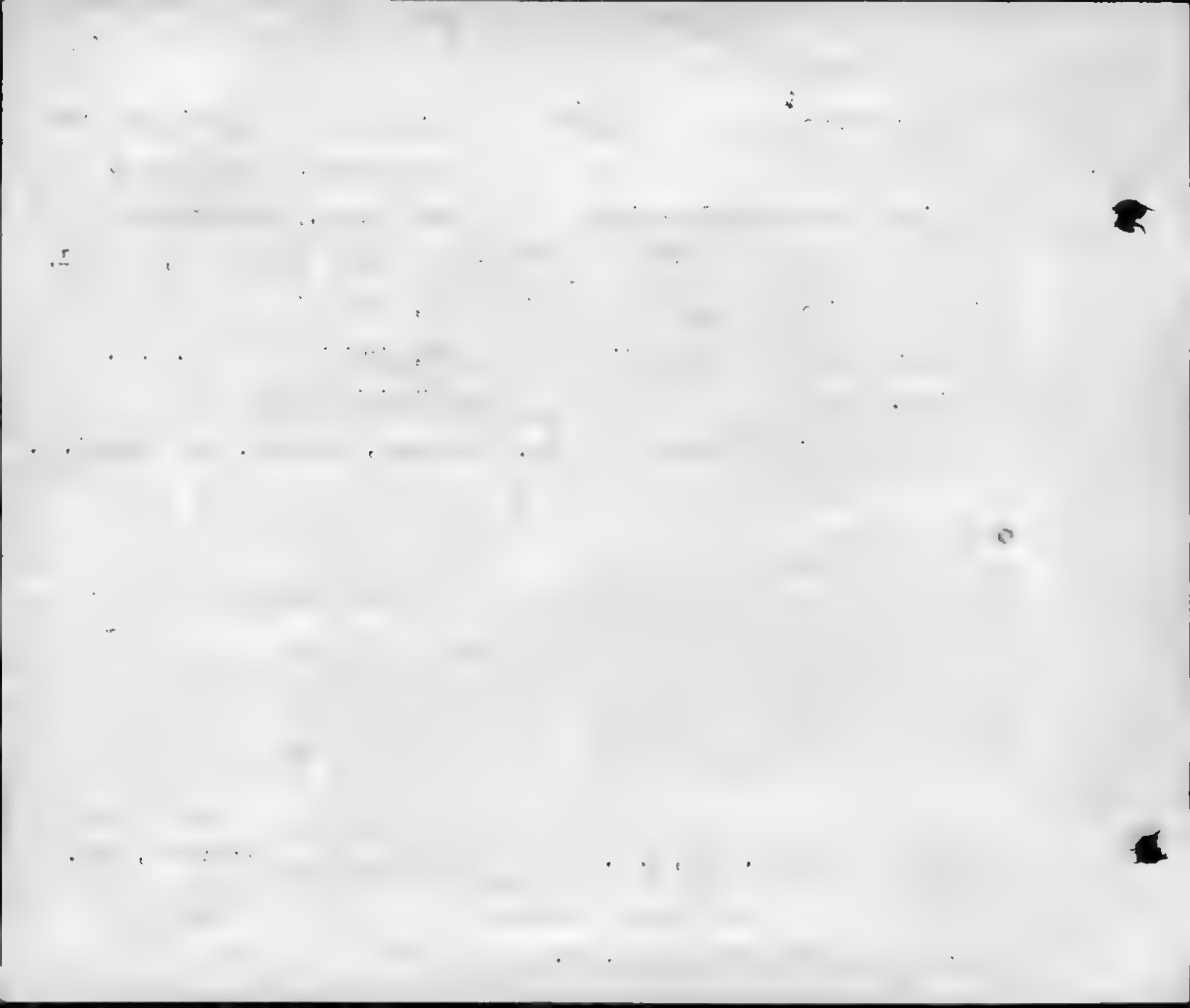
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 14 days of death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

14
FOR STATE
HEALTH DEPT.
(M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1034 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN b 1034 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince Georges General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6917 Adel Street Seat Pleasant d. STREET ADDRESS 6917 Adel St., Seat Pleasant e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD First ARTHUR Middle JEWELL Last		4. DATE OF DEATH Month January Day 5 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 19, 1906	
9. AGE (in years last birthday) 54 yrs.		10. IF UNDER 1 YEAR: Months 5 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plaster		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Fairfax, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edwin C. Jewell		14. MOTHER'S MAIDEN NAME Laura Virginia Havener	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Peacetime USN unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Mrs. Ruth Yowell, 6504 A St. Seat Pleasant, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inter cerebral hemorrhage 444-X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hypertensive Cardiovascular disease causa last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE JAMES I. BOYD, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES I. BOYD, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED January 5, 1961.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 10, 1961	
22c. NAME OF CEMETERY OR CREMATORIAL Arlington National		22d. LOCATION (City, town, or country) (State) Arlington Virginia	
23. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.		24a. REC'D BY REGISTRAR JAN 11 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kinn	



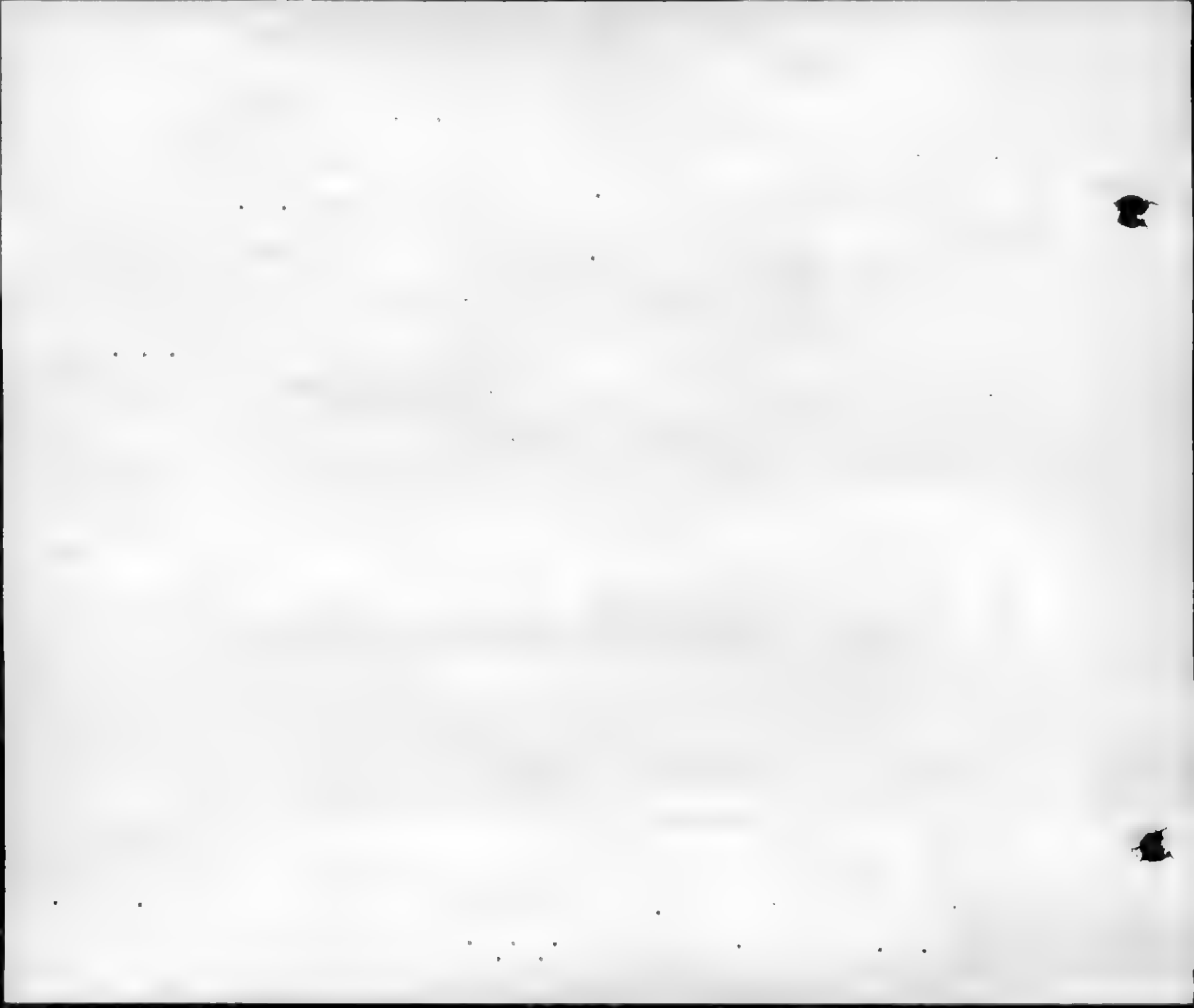
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

(1025)

1035

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3120 Powder Mill Rd. Paint Branch Nursing Home				d. STREET ADDRESS 1021 Otis Street N. E.			
3. NAME OF DECEASED (Type or print) First Hilma Middle C. Last Jones				4. DATE OF DEATH Month January Day 7 Year 19 61			
5 SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1881		9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sweden		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Abram Wiklund			14. MOTHER'S MAIDEN NAME Christina Hendrikess Dotter				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Decedent			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Heart Disease DUE TO (c) generalized arterio Sclerosis							INTERVAL BETWEEN ONSET AND DEATH 11/7/61 10-20 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Parkinsons Syndrome ② 3/24/58 fracture skull							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) fracture ribs 3/24/58					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from 11/4/57 to 11/7/61 , 19____, that (I) (we) last saw the deceased alive on 12/20/60 , and that death occurred on ____ M., from the causes and on the date stated above.							
22a. SIGNATURE John J. Sweeney M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) John J. Sweeney				22d. ADDRESS 1238 Monroe St NE			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/10/61		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.				25a. REC'D BY REGISTRAR 2901 14th St. N. W. Washington, D. C.		25b. REGISTRAR'S SIGNATURE DATE JAN 9 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1036

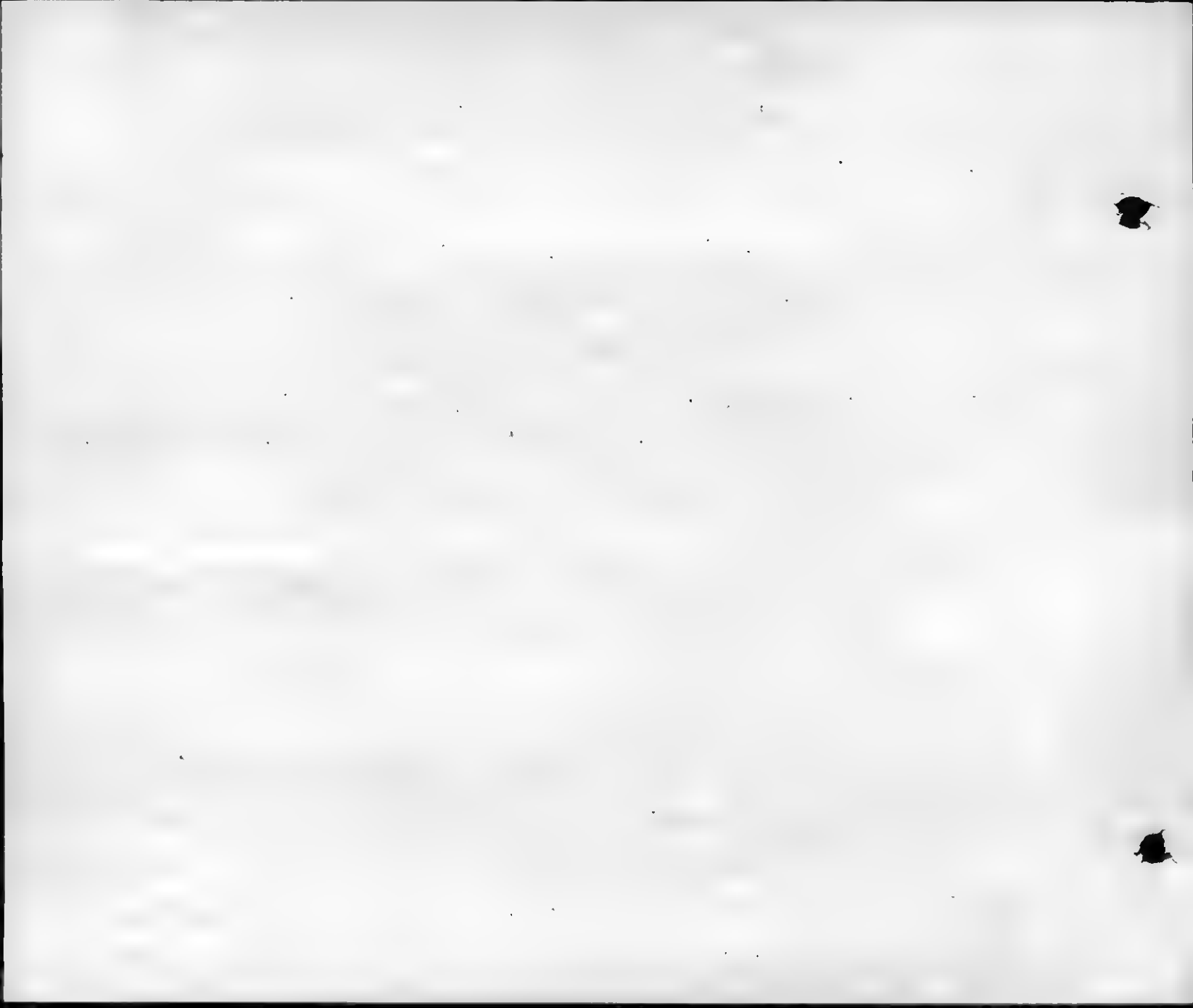
11020

1. PLACE OF DEATH COUNTY <u>Prince Georges</u> <u>Beltzville md</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Amundale</u> <u>Normal Institute</u> COUNTY <u>Prince Georges Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltzville md</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltzville md</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>		d. STREET ADDRESS <u>Beltzville C. D. md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Brother Denis</u> First <u>HENRY</u> Middle <u>A.</u> Last <u>JUERGENS</u> <u>Brother Denis Edward</u>				4. DATE OF DEATH Month <u>1</u> Day <u>8</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 18 1870</u>	
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Teacher, Brothers</u>		11. BIRTHPLACE (State or foreign country) <u>Penn.</u> <u>U. S. A. Philadelphia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Ferdinand Juergens</u>				14. MOTHER'S MAIDEN NAME <u>Margaretha Hertlein</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO (If yes give war or dates of service) <u>None</u>		17. INFORMANT <u>Brother Francis Benilde Beltzville md</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertatic pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>C-S Cardiovascular Dis</u> <u>5 yrs.</u>							
DUE TO <u>Gen'l arteriosclerosis</u> <u>20 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/3/58</u> 19 <u>to</u> <u>1/7</u> 1960 that (I) last saw the deceased alive on <u>1/6</u> 1960 and that death occurred at <u>11/7</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>J M Warren</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/8/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. M. WARREN</u>				22d. ADDRESS <u>305 Prince George Street, Laurel Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>January 11, 1961</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Christian Brothers Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Amundale, Beltzville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO., Riverdale, Md</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>		25b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 12 '61</u>							

(M)

094

(I)



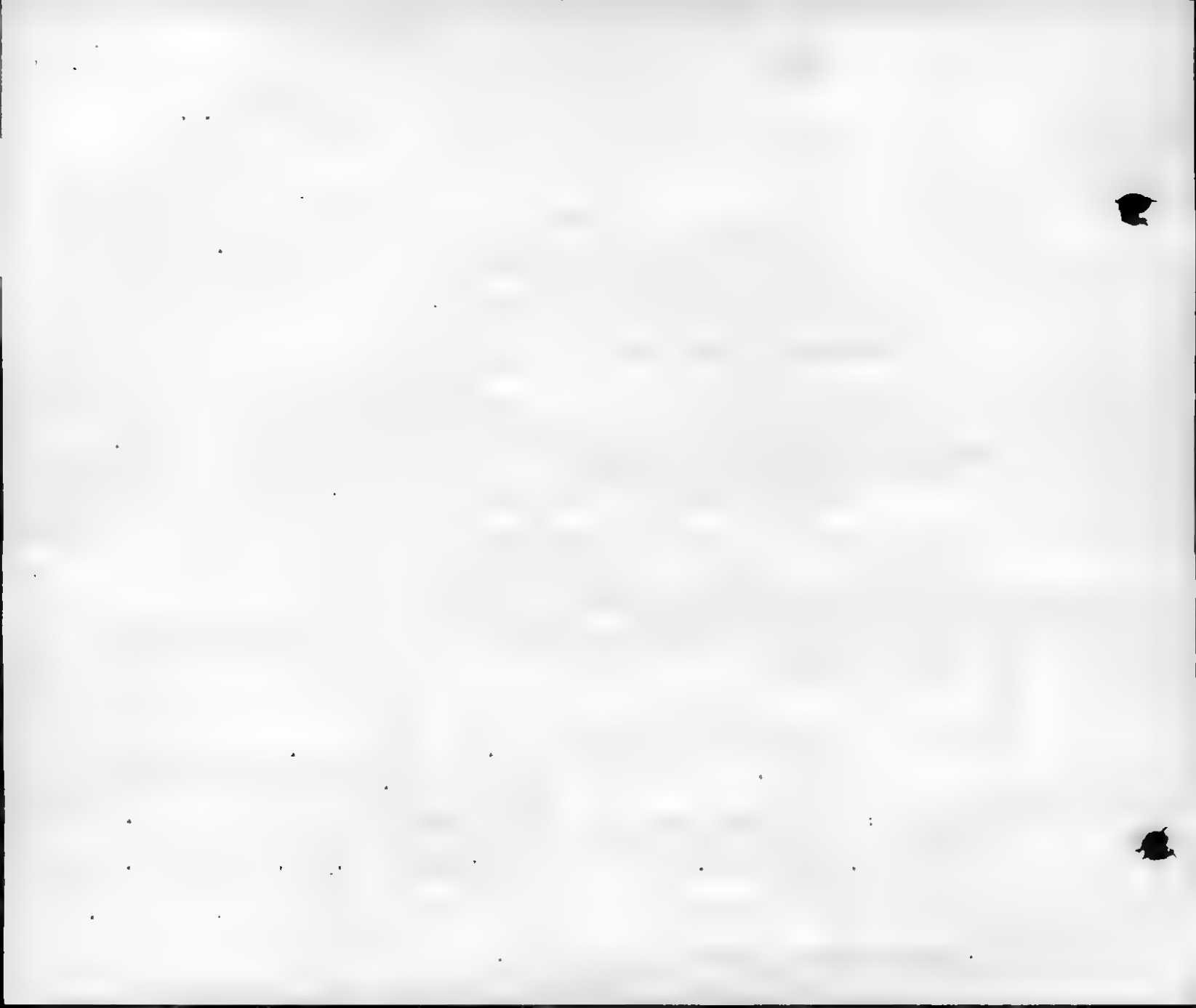
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1037

1021

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY P.G.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood			c. LENGTH OF STAY IN 1b 3 years			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5006 Hollywood Road				d. STREET ADDRESS 5006 Hollywood Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Barbara Middle Anne Last Kemerer				4. DATE OF DEATH Month Jan. Day 7 Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1931		9. AGE (In years last birthday) 29 yrs.	IF UNDER 1 YEAR Months 29 Days 7 Hours 1 Min 1
10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Cecil B Hall				14. MOTHER'S MAIDEN NAME Mildred E Sears			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 577 42 5753		17. INFORMANT James M Kemerer Address Hollywood Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema and Bilateral Hydrothorax 75441 DUE TO (b) Patent Ductus Arteriosus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Congenital Heart Disease							INTERVAL BETWEEN ONSET AND DEATH 24 hours from birth from birth
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1961 to Jan. 7, 1961 that (I) (we) last saw the deceased alive on Jan. 6, 1961 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Charles C. Hageage</i>				22b. DATE Jan. 7, 1961		22c. PHYSICIAN'S NAME (Type) Charles C. Hageage M.D.	
22d. ADDRESS 3308 Perry St., Mt. Rainier, Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 10, 1961		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				25a. REC'D BY REGISTRAR DATE JAN 11 '61		25b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>	



1038

CERTIFICATE OF DEATH

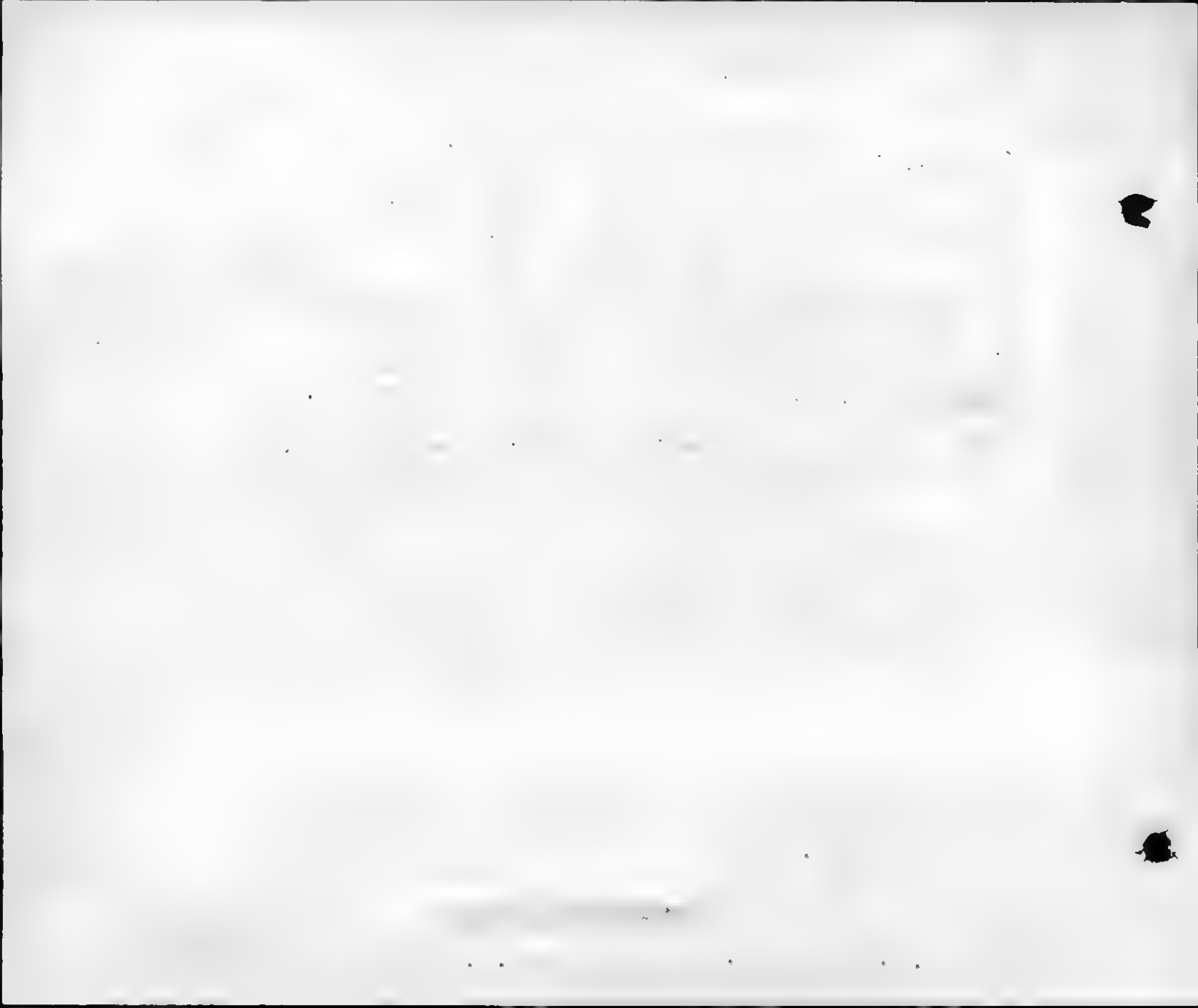
Reg. Dist. No.

(1028)

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3120 Powder Mill Road</u> <u>Hyattsville</u>		c. LENGTH OF STAY IN 1b <u>6 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Point Branch Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Coro</u> Middle <u>Etha</u> Last <u>Koons</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>7</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 30, 1871</u>
9. AGE (In years last birthday) <u>29</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	11. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator boardline house - Private</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>David Crain</u>		14. MOTHER'S MAIDEN NAME <u>Mary M. Crain</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Nursing Home Records</u>		Address <u>Prince Georges</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>422</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> 19 <u>56</u> to <u>Jan 7</u> 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 5</u> 19 <u>61</u> , and that death occurred at <u>10:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James M. Whitlock</u>		ADDRESS (Street, city or town, state) <u>7717 Carroll Ave Takoma Park Md</u>	
PHYSICIAN'S NAME (Type) <u>James M. Whitlock</u>		DATE SIGNED <u>1-7-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>1/9/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Plymouth Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Plymouth, Ohio</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co. Washington, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 9 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>C. E. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

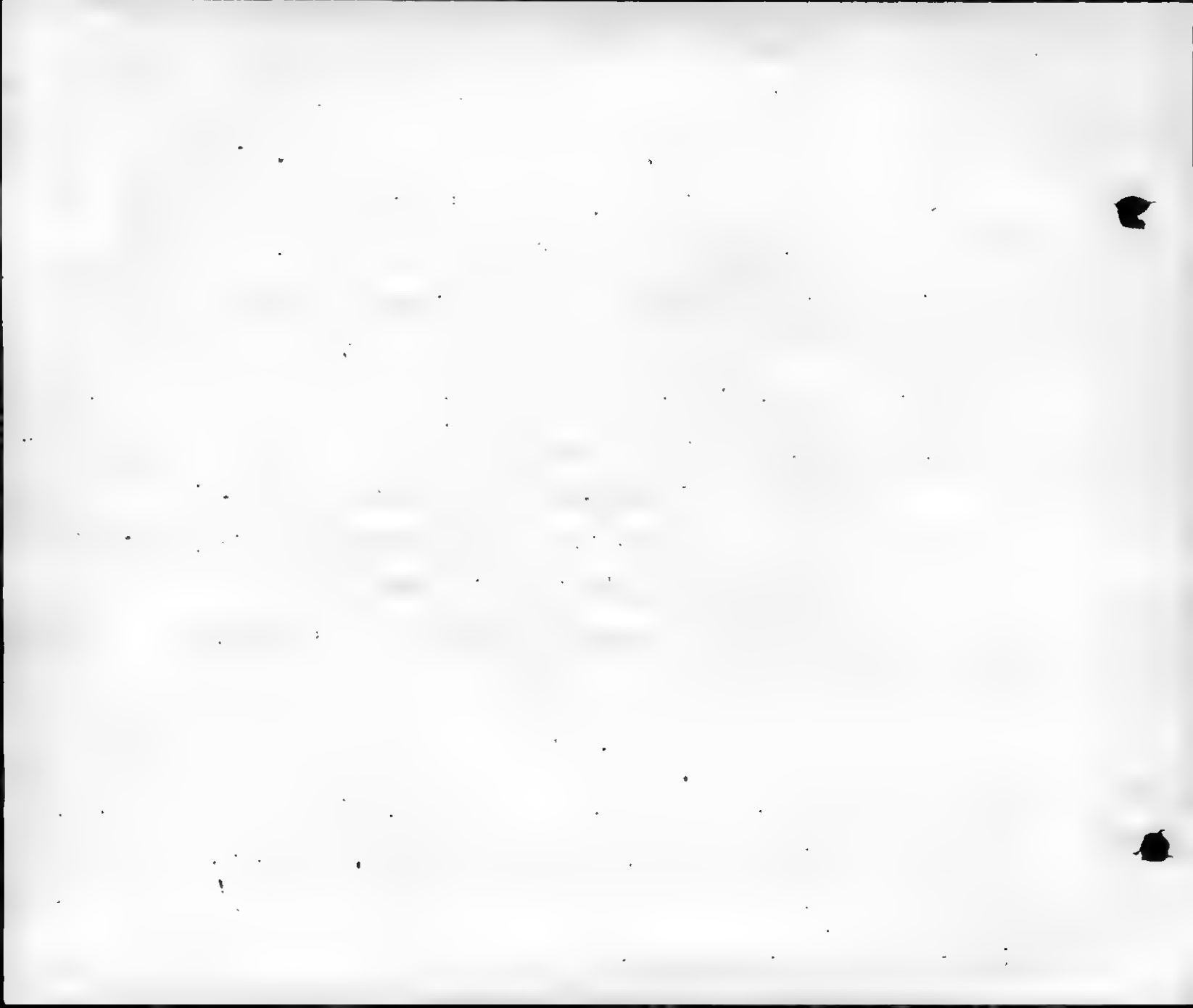


CERTIFICATE OF DEATH

64029

MEDICAL CERTIFICATION

VS A15 (4)
1SM 9/5B



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please return the certificate, writing the word "pending" in pencil in item 18. Give item 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

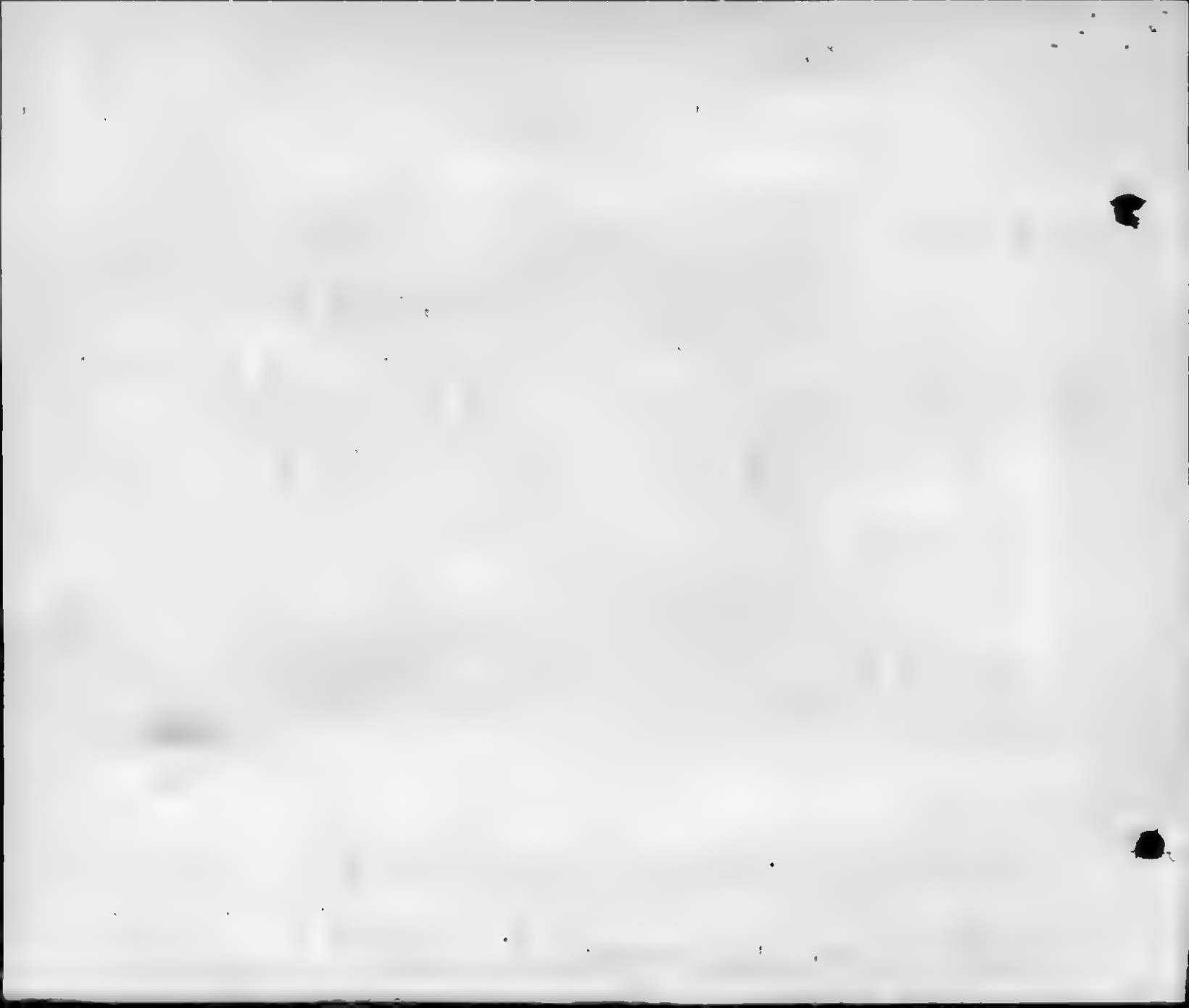
VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1040 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11030

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if not put on: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brightseat		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brightseat	
c. LENGTH OF STAY IN 1b 42 years		d. STREET ADDRESS Brightseat Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Brightseat Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Herman Kuenne		4. DATE OF DEATH January 6 1961	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH March 25, 1905		9. AGE (In years last birthday) 55 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Wisconsin	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Volkmar Kuenne		14. MOTHER'S MAIDEN NAME Bertha Morganegg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Raymond Kuenne, same as # 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dementia praecox 300.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. a. Refused food was badly nourished		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County, (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ASS. STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED 1/9/61		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/61	
22c. NAME OF CEMETERY OR CREMATORY Epiphany Cemetery		22d. LOCATION (City, town, or country) (State) Forestville, Md.	
23. FUNERAL DIRECTOR Ritchie Bros. Fun'l Home - Upper Marlboro		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

JAN 16 '61

Arthur S. Kraus



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1041 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(106)

1. PLACE OF DEATH a. COUNTY Prince Georges		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Prince George's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN lb D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		d. STREET ADDRESS 6017 Inwood St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward CLARENCE KUHN		First Middle Last		4. DATE OF DEATH Month Day Year January 6 1961	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH July 25, 1920		9. AGE (In years last birthday) yrs 40		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pressman		10b. KIND OF BUSINESS OR INDUSTRY Evening Star Newspaper Jimthorp, Penns.		11. BIRTHPLACE (State or foreign country) U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edwin Kuhn		14. MOTHER'S MAIDEN NAME Mary Butchko	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give dates of service) Yes WWII		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mrs. Martha R. Kuhn, 6017 Inwood St., Cheverly, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary infarction 23.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary thrombosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/6/61	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-10-61		22c. NAME OF CEMETERY OR CREMATORY Arlington National	
				22d. LOCATION (City, town, or country) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR W.W. Chambers Co.		ADDRESS Riversdale, Md		24a. REC'D BY REGISTRAR 12 61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume	



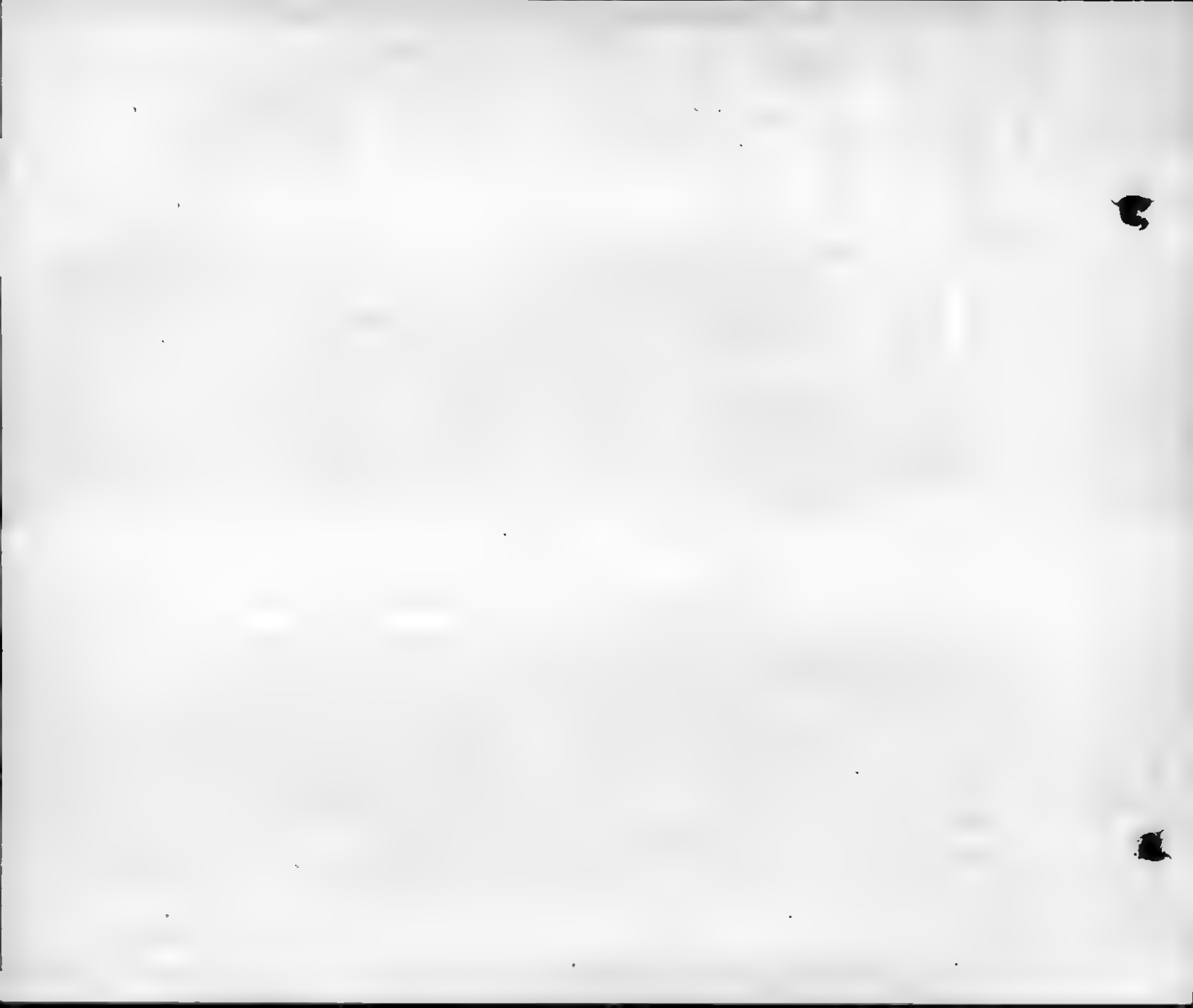
1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1042 CERTIFICATE OF DEATH

Reg. Dist. No. 1102

1. PLACE OF DEATH o. COUNTY <i>Prince George's</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Prince George's</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol Heights</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Capitol Heights</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>621-51st Avenue</i>		d. STREET ADDRESS <i>621-51st Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>FLORENCE May LAMBERT</i>		4. DATE OF DEATH Month <i>1</i> Day <i>4</i> Year <i>1961</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-20-1880</i>
9. AGE (In years last birthday) <i>80</i> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John H. Compher</i>		14. MOTHER'S MAIDEN NAME <i>Spring</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>621-51st Ave</i>	
17. INFORMANT <i>Ruth Naizn</i>		Address <i>Capitol Heights</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiac failure</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO (c) <i>Generalized arteriosclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i> <i>10 yrs</i> <i>10 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 1957</i> to <i>4-1961</i> , that I last saw the deceased alive on <i>1-4-1961</i> , and that death occurred at <i>10:46</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Peter D. Dicus</i> M.D.		ADDRESS (Street, city or town, state) <i>6124 Central Ave</i>	
PHYSICIAN'S NAME (Type) <i>PETER D. Dicus</i>		DATE SIGNED <i>1-4-61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Jan 7, 1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Addison Chapel Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Seat Pleasant Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville, Md.</i>	
24a. REC'D BY REGISTRAR <i>JAN 9 '61</i>		24b. REGISTRAR'S SIGNATURE <i>C. S. F. Jones</i>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The funeral director, after this certificate has been signed by the attending physician and completely filled in, should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

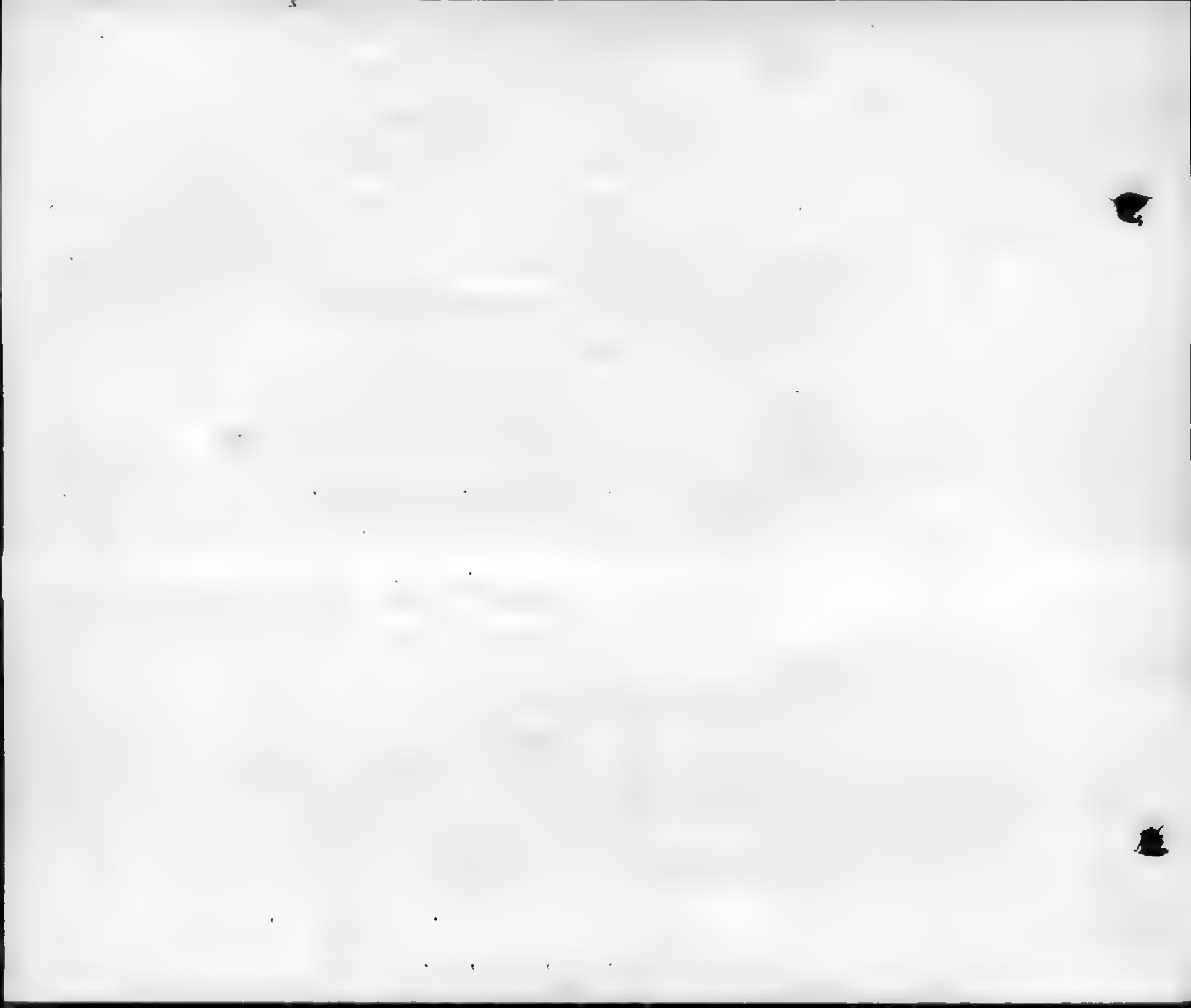
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1043 CERTIFICATE OF DEATH

64083

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE VIRGINIA b. COUNTY FAIRFAX			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Andrews AFB				c. LENGTH OF STAY IN 1b 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FAIRFAX			
f. STREET ADDRESS Glenbrook Road				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KURT M LONDON				4. DATE OF DEATH JANUARY 3 1961			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 16 JAN 1908	
9. AGE (in years last birthday) 52 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US AIR FORCE				10b. KIND OF BUSINESS OR INDUSTRY MILITARY SERVICE		11. BIRTHPLACE (State or foreign country) MISSOURI	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME PERRY OLIVER LONDON				14. MOTHER'S MAIDEN NAME HELEN HEMPEL			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes no or unknown) YES (If yes, give war or dates of service) 1926-1958				16. SOCIAL SECURITY NO. 1926-1958		17. INFORMANT TRUMAN LONDON (BROTHER) Address [REDACTED]	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute pulmonary edema							8 hrs
DUE TO (b) Renal and Cardiac failure							30 days
DUE TO (c) Chronic lymphatic leukemia							3 years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 16 DEC 1960 to 3 JAN 1961 that (I) (we) last saw the deceased alive on 2 JAN 1961 and that death occurred at 2:45 PM from the causes and on the date stated above.							
22a. SIGNATURE Andrew W. Butchko M D				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 3 January 1961	
22c. PHYSICIAN'S NAME (Type) ANDREW W BUTCHKO, CAPT USAF MC				22d. ADDRESS USAF HOSP ANDREWS ANDREWS AFB WASH 25 DC			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/6/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Rinaldi Funeral Home ADDRESS 816 H St., NE, Wash, DC				25a. REC'D BY REGISTRAR DEC 9 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

Michael J. Rinaldi



CERTIFICATE OF DEATH

Reg. Dist. No.

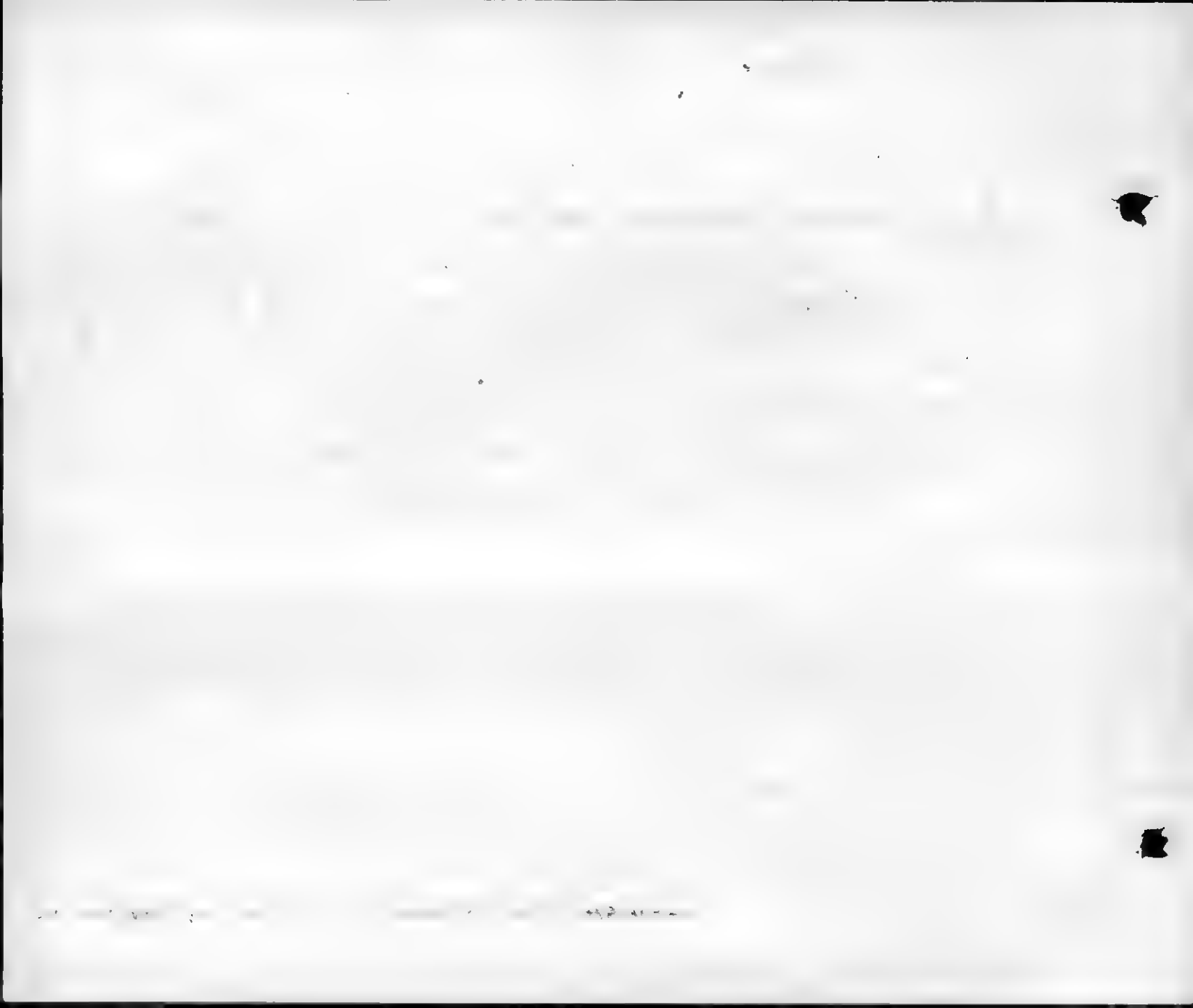
1004

1044

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Adelphi</u>				c. LENGTH OF STAY IN 1b <u>2 yrs. 3 mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural Hospital for the Deaf</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>4 in</u>			
f. STREET ADDRESS <u>1360 1st Ave NW</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Don</u> Middle <u>Stearman</u> Last <u>Lewis</u>				4. DATE OF DEATH Month <u>January</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jun. 2, 1888</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>			
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Lewis Stearman</u>				14. MOTHER'S MAIDEN NAME <u>Sarah</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>57-42-4411</u>			
17. INFORMANT <u>Nursing Home Records</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u></u> 19 <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>10-5-58</u> 19 <u>58</u> to <u>1-27-61</u> 19 <u>61</u> , that I last saw the deceased alive on <u>1-26</u> 19 <u>61</u> , and that death occurred at <u>1:55 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Whitlock, M.D.</u>				ADDRESS (Street, city or town, state) <u>7717 Canale Ave</u>			
PHYSICIAN'S NAME (Type) <u>JAMES M. WHITLOCK, M.D. Takoma Park, Md.</u>				DATE SIGNED <u>1-27-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-29-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ONEV SHOLOM TALMUD TORAH CEM - WASHINGTON D.C.</u>		22d. LOCATION (City, town, or county) (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BERNARD DANZANSKY & SONS - 3501-14th NW</u>				24a. REC'D BY REGISTRAR <u>FEB 1 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Korman</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1045

CERTIFICATE OF DEATH

Reg. Dist. No.

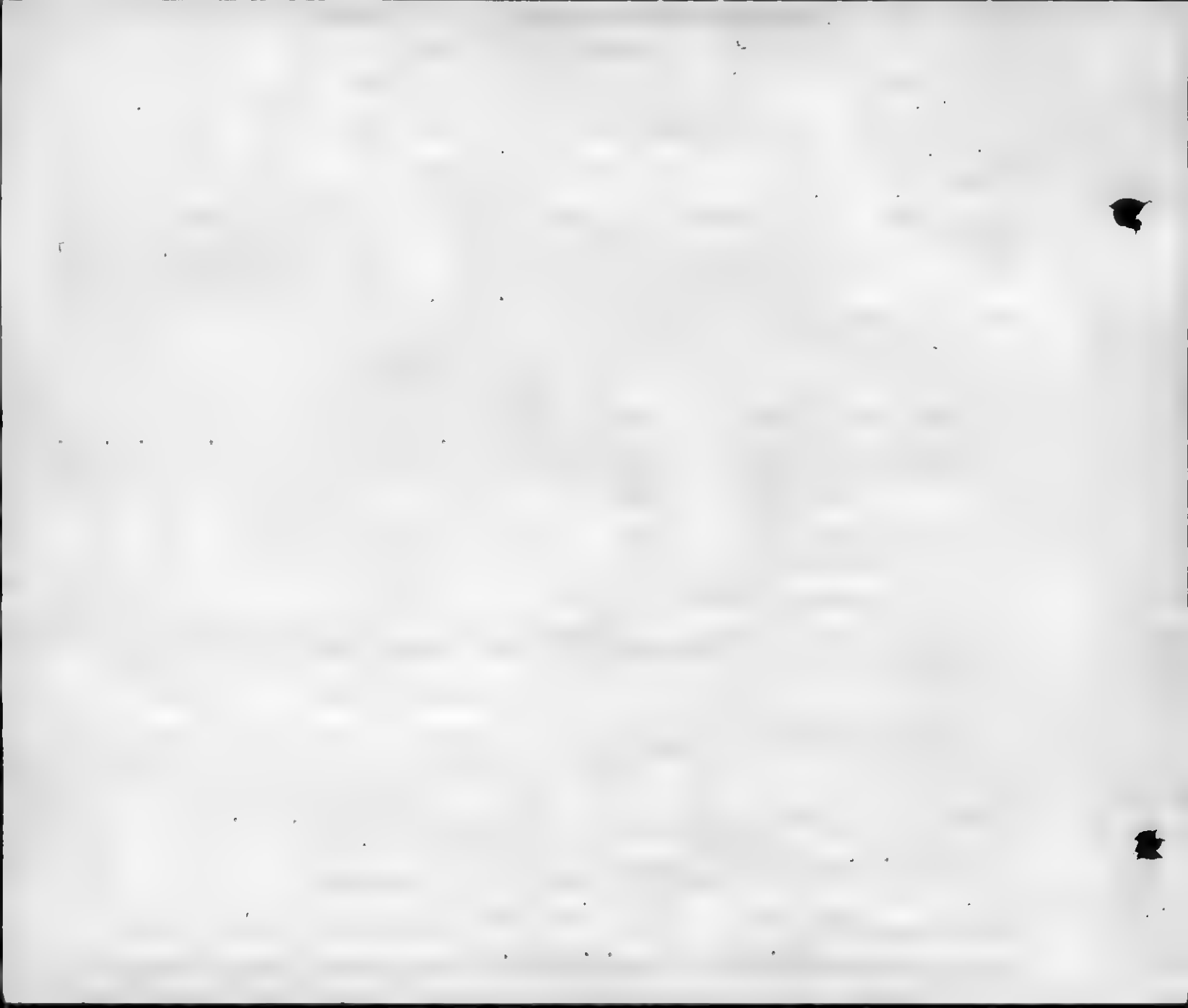
(105)

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) 2311 Kirby Drive		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights (Wash. 21, DC)	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle JOSEPH Last LOWE		4. DATE OF DEATH Month January 3rd, Day 3rd, Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30th, 1960
9. AGE (In years last birthday) yrs. 4		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None--Infant		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Leroy Lowe		14. MOTHER'S MAIDEN NAME Adelaide Andrews	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give year or dates of service) None		16. SOCIAL SECURITY NO None	
17. INFORMANT Address Hillcrest Heights Adelaide A. Lowe, 2311 Kirby Dr. Wash. 21, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.5 DUE TO <u>Constitutional Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 30, 1960, to Jan 3, 1961, that I last saw the deceased alive on Jan 1, 1961, and that death occurred at 1:30P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. J. Terrafranca		ADDRESS (Street, city or town, state) # 8 Barney Circle, S.E. DATE SIGNED 1/3/1961	
PHYSICIAN'S NAME (Type) R. J. Terrafranca		Washington, D.C.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/5/61	22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery	22d. LOCATION (City, town, or county) (State) Suitland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W.W. CHAMBERS COMPANY, 517--11th St. S.E. Wash. DC		24a. REC'D BY REGISTRAR DATE JAN 5 '61	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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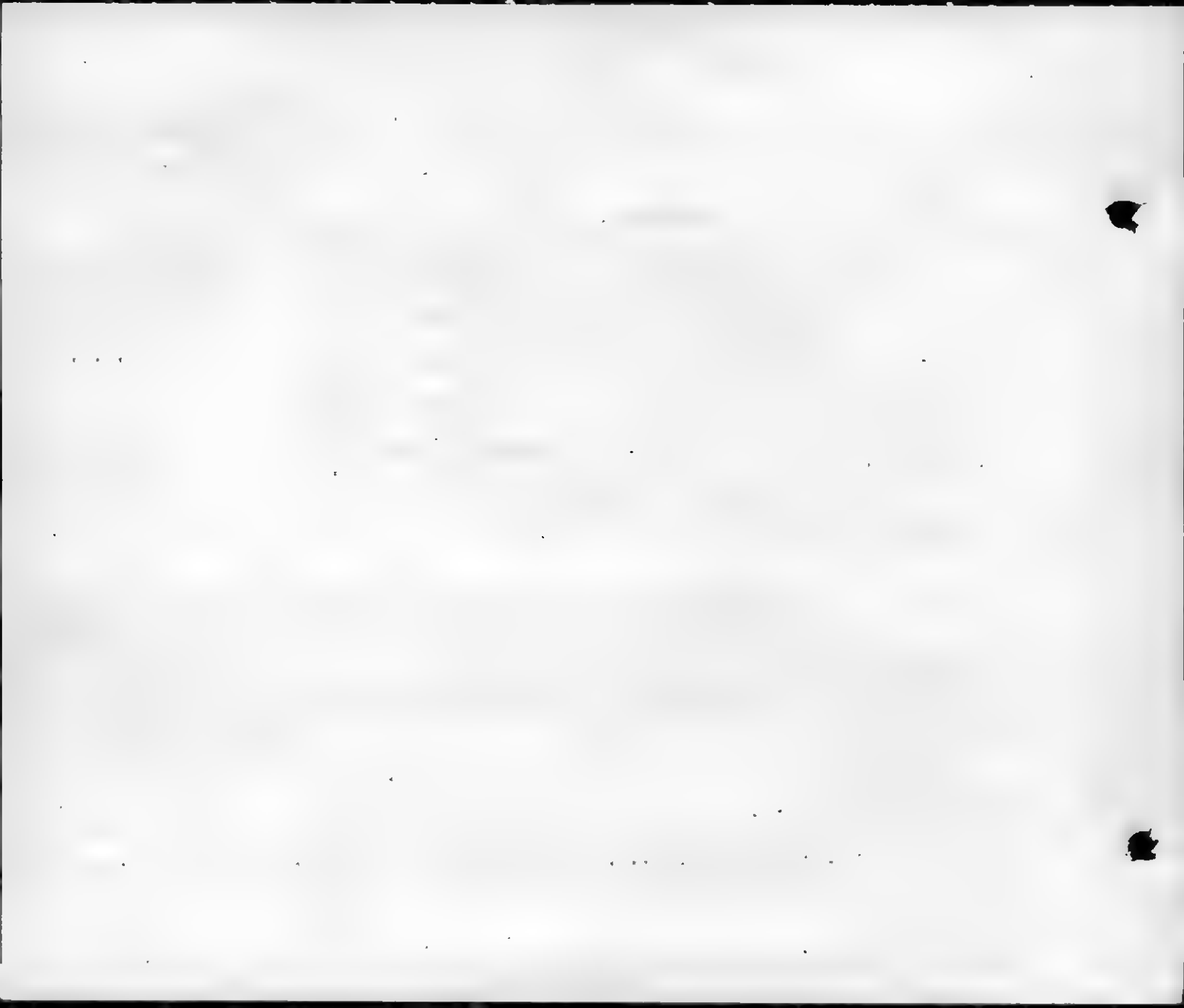


may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1046
CERTIFICATE OF DEATH

61056

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills (Deer Park)			
c. LENGTH OF STAY IN 1b 15 min				d. STREET ADDRESS 2102 Marilyn Drive			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Genral Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Edward Matnews				4. DATE OF DEATH Month Day Year Jan 7 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 NOV 1907	
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Penn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mail Carrier				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Berte Matnews				14. MOTHER'S MAIDEN NAME Elizabeth Walker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO Unknown		17. INFORMANT Address Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-16X Acute heart failure DUE TO (b) Rheumatic heart disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hemiplegia rt due to C.V.A.							INTERVAL BETWEEN ONSET AND DEATH 1 hr 30 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1957, to 7 Jan 1961 19, that (I) (we) last saw the deceased alive on 7 Jan 1961 and that death occurred at 11:45 PM from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/7/60	
22c. PHYSICIAN'S NAME (Type) Dr. Peter Duus, Md.D.				22d. ADDRESS 6124 Central Ave. Capitol Hgts., Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/11/61		23c. NAME OF CEMETERY OR CREMATORY L.O.O.F. Cemetery		23d. LOCATION (City, town, or county) (State) Briston, Pennsylvania	
24. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS 7557 Waxman Ave, Bethesda, Md		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE [Signature]	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5.6 Film G279 1-27-61 et

CERTIFICATE OF DEATH

1047

Item 13 Film G284 4/4/61 iwk

Reg. Dist. No.

11007

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) West Hyattsville				c. LENGTH OF STAY IN lb 5 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mrs. Bell's Nursing Home for Children				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly			
f. STREET ADDRESS 3407 Bellview Avenue				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph First		Middle Edward		Last Mazur		4. DATE OF DEATH Month Jan. Day 23, Year 19 61	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/60		9. AGE (In years last birthday) yrs. 6	IF UNDER 1 YEAR IF UNDER 24 HRS Months 6 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Mazur Mazur				14. MOTHER'S MAIDEN NAME Elizabeth Bobalik			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Joseph Mazur Same as # 2 (Father)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hydrocephalus (internal) marked 752X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute respiratory collapse DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/1/61 to 1/23/61 , that I last saw the deceased alive on 1/23/61 , and that death occurred at 8:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Thomas A. Christensen				ADDRESS (Street, city or town, state) 6905 Back Blvd		DATE SIGNED 1/23/61	
PHYSICIAN'S NAME (Type) Collage Park, Md							
22a. BURIAL, CREMATION, REMQVAL (Specify) Burial		22b. DATE THEREOF 1/24/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Maryland		24a. REC'D BY REGISTRAR DATE JAN 24 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

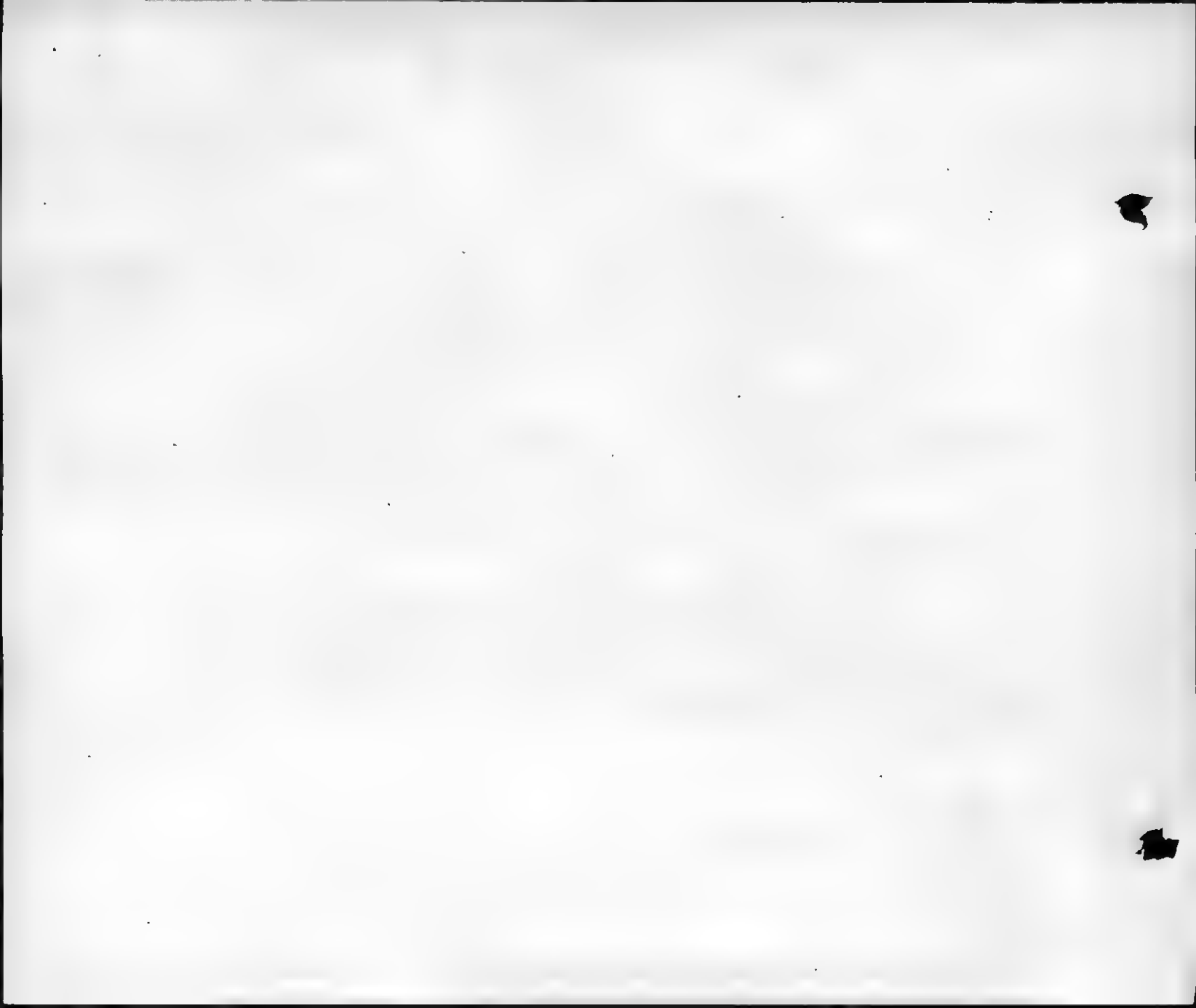
TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



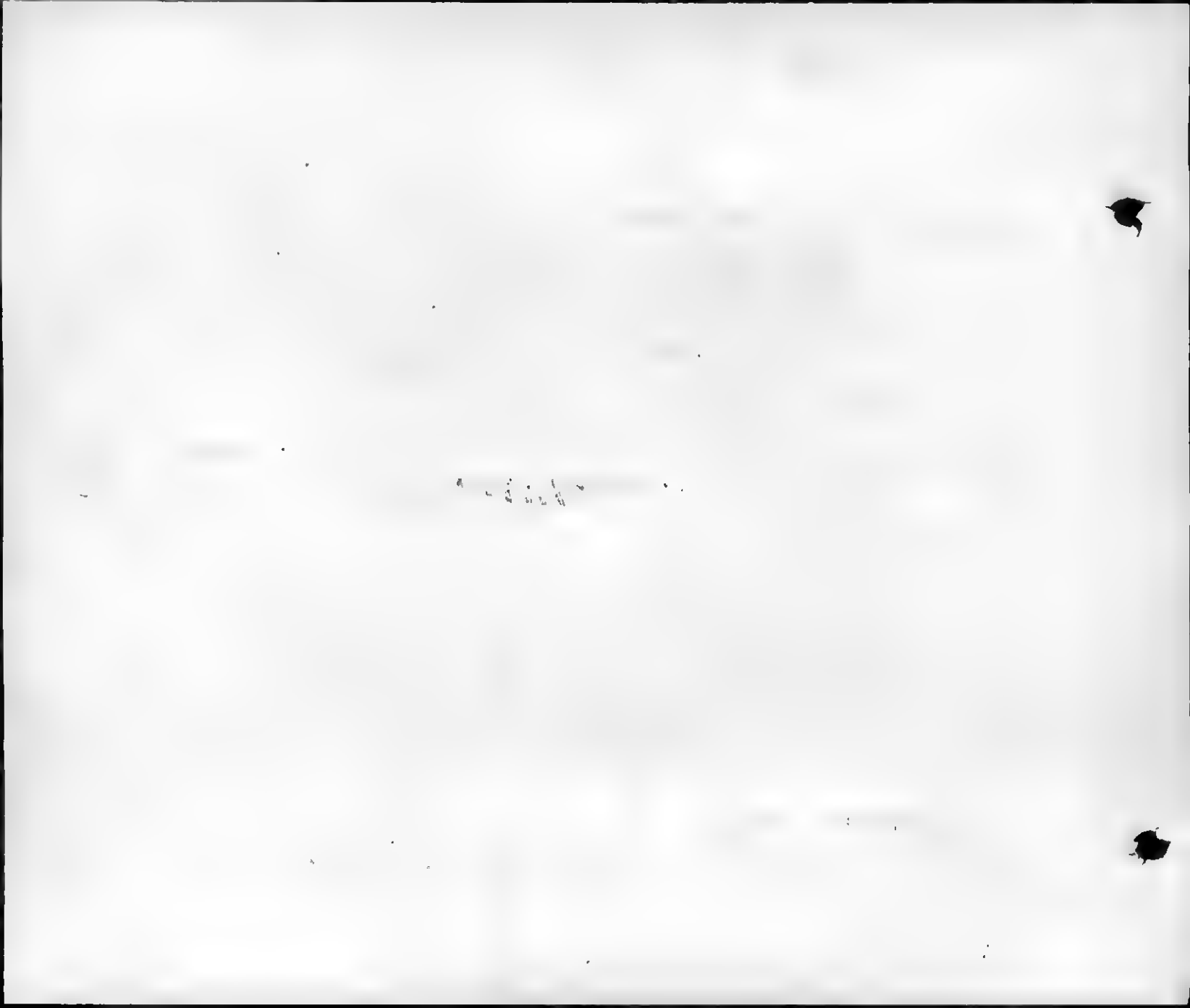
1048

1008

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md				c. LENGTH OF STAY IN lb D O A.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Md.			
f. STREET ADDRESS 3149 Queens Chapel Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Thomas Francis Mc Donough				4. DATE OF DEATH Month Day Year January 28, 19 61-			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1896	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U S A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Typewriter			
11. BIRTHPLACE (State or foreign country) Maine				12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Anthony Mc Donough				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) W W 1		16. SOCIAL SECURITY NO yes 005 03 0009		17. INFORMANT Frank E Mc Donough Mt Rainier Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.2 DUE TO myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 1 wk			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4:05 to 1-28 , 19 61 , that (I) (we) last saw the deceased alive on 1-26 , 19 61 , and that death occurred at 4 M, from the causes and on the date stated above.							
22a. SIGNATURE Leonard Hays				22b. DATE 1-28-61			
22c. PHYSICIAN'S NAME (Type) Leonard Hays				22d. ADDRESS Hyattsville Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 31, 1961		23c. NAME OF CEMETERY OR CREMATORY Mt Hope		23d. LOCATION (City, town, or county) (State) Lewiston Maine	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				25a. REC'D BY REGISTRAR DATE FEB 2 '61			
ADDRESS Hyattsville Md.				25b. REGISTRAR'S SIGNATURE William E. K...			

I



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

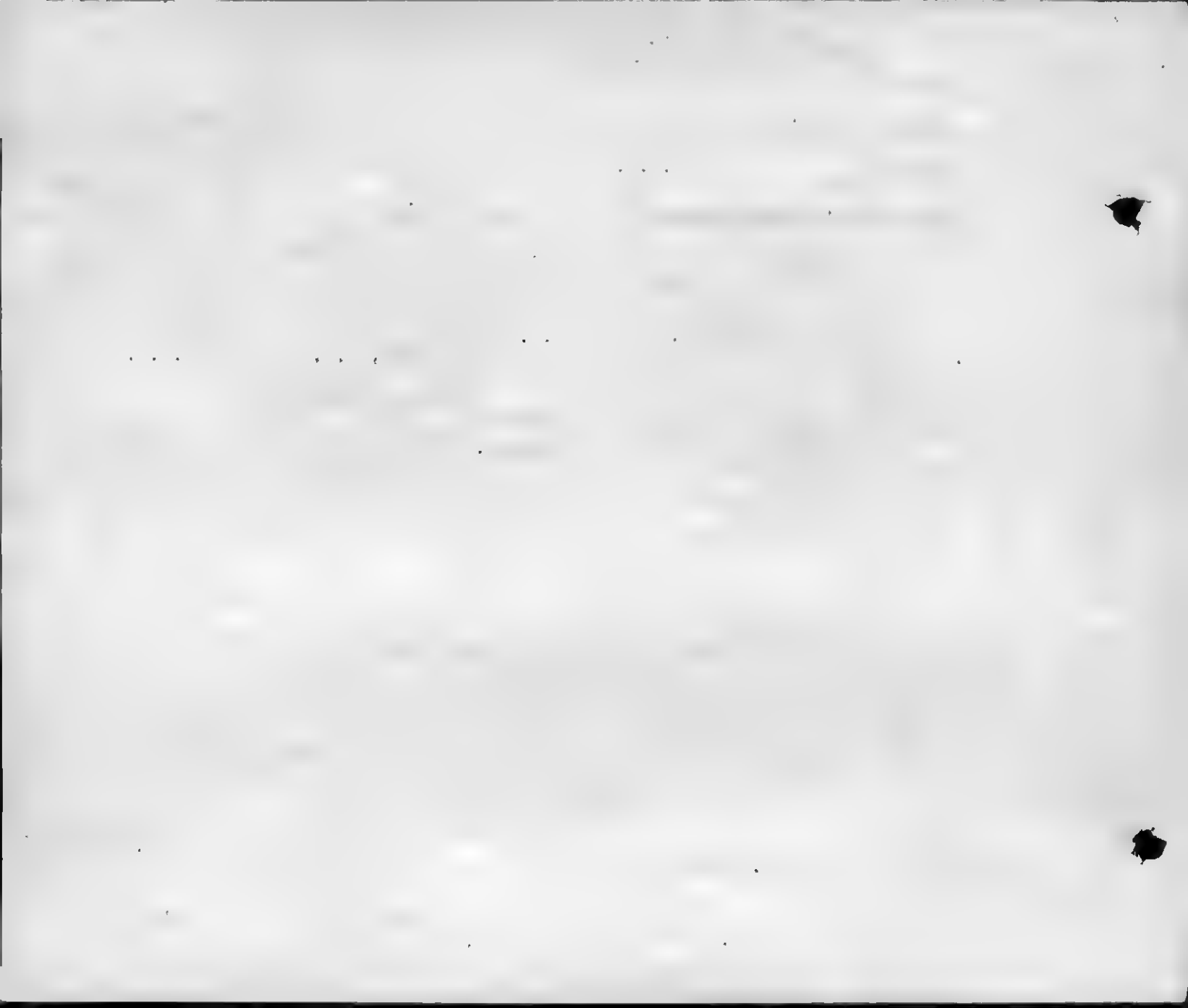
MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1049 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(1009)

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> c. LENGTH OF STAY IN <u>MD.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Prince George's General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>West Hyattsville</u> d. STREET ADDRESS <u>623 Sheridian St</u>	
3. NAME OF DECEASED (Type or print) <u>Marvin (NMI) McKEE</u>		4. DATE OF DEATH <u>January 14 19 61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>24 March 1906</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ass. Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nat'l. Bank of D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John McKee</u>		14. MOTHER'S MAIDEN NAME <u>Parthenia Brummett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-09-1781</u>	
17. INFORMANT <u>Mary E. McKee (Same as # 2)</u>		Address <u>(Wife)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive heart failure</u> 442 X DUE TO (b) <u>Cardiovascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/17/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or country) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR <u>WALTER E. PUMPHREY, INC.</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>Raymond A. Zicka</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>JAN 25 '61</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1050

CERTIFICATE OF DEATH

Reg. Dist. No. 13040

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville (Chillum Heights)</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Hyattsville (Chillum Heights)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>909 Somerset Place</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH KEMSTER MORGAL</u>				4. DATE OF DEATH Month Day Year <u>Jan. 17 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 28 1891</u>	9. AGE (In years last birthday) <u>69</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Toolmaker</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Lewis Morgal</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Lynch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT <u>Hazel Mrs. Morgal</u> Address <u>- same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> (b) <u>arteriosclerotic cardiovascular dis.</u> (c) <u>inter</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 min</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>not</u>					
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 13</u> , 19 <u>61</u> , to <u>Jan. 17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan. 13</u> , 19 <u>61</u> , and that death occurred at <u>10:15</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William F. Simpson Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>6216 N.H. Ave. N.E. Washington, D.C.</u>		DATE SIGNED <u>1/17/61</u>	
PHYSICIAN'S NAME (Type) <u>William F. Simpson Jr.</u>				ADDRESS <u>Washington, D.C.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/21/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H.Hines Co. - 2901 14th St., N.W. Washington 9, D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>C. S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1051

UNITED STATES DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

(1114)

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Laurel	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS 510 Haines Rd	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle L Last Morris		4. DATE OF DEATH Month January Day 25 Year 19 61	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 1 / 1961
9. AGE (In years last birthday) - yrs 21		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Md. Baltimore	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Stewart Wm. Morris		14. MOTHER'S MAIDEN NAME Elizabeth Jean Chaney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) '763.0 DUE TO Respiratory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-23 1961 to 1-25 1961, that (I) (we) last saw the deceased alive on 1-25 1961, and that death occurred at 3/35 from the causes and on the date stated above			
22a. SIGNATURE A. J. Modlin		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. A. J. Modlin, M.D.		22d. ADDRESS 300 Montrose Ave., Laurel, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/27/61	23c. NAME OF CEMETERY OR CREMATORY Ivy Hill Cem.	23d. LOCATION (City, town, or county) (State) Laurel Md
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE FEB 1 '61			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1052

CERTIFICATE OF DEATH

Reg. Dist. No. 1042

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Rainier</u>	
c. LENGTH OF STAY IN 1b <u>about 2 yrs.</u>		d. STREET ADDRESS <u>3711-34th street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3711-34th street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Delores D. Mulholland</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>25</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 3 1912</u>
9. AGE (In years last birthday) <u>48</u> yns.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Plumbhoff</u>	
14. MOTHER'S MAIDEN NAME <u>Anna K. Shisslett</u>		15. WAS DECEASED A MEMBER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>	

16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>John J. Mulholland</u> Address <u>3711-34th St. Mt. Rainier, Md.</u>	
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary thrombosis</u> DUE TO (c) <u>Generalized atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>14 hours</u> <u>24 hours</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1958, 19____, to 1961, 19____, that I last saw the deceased alive on Jan 25, 1961, and that death occurred at 2nd M, from the causes and on the date stated above.

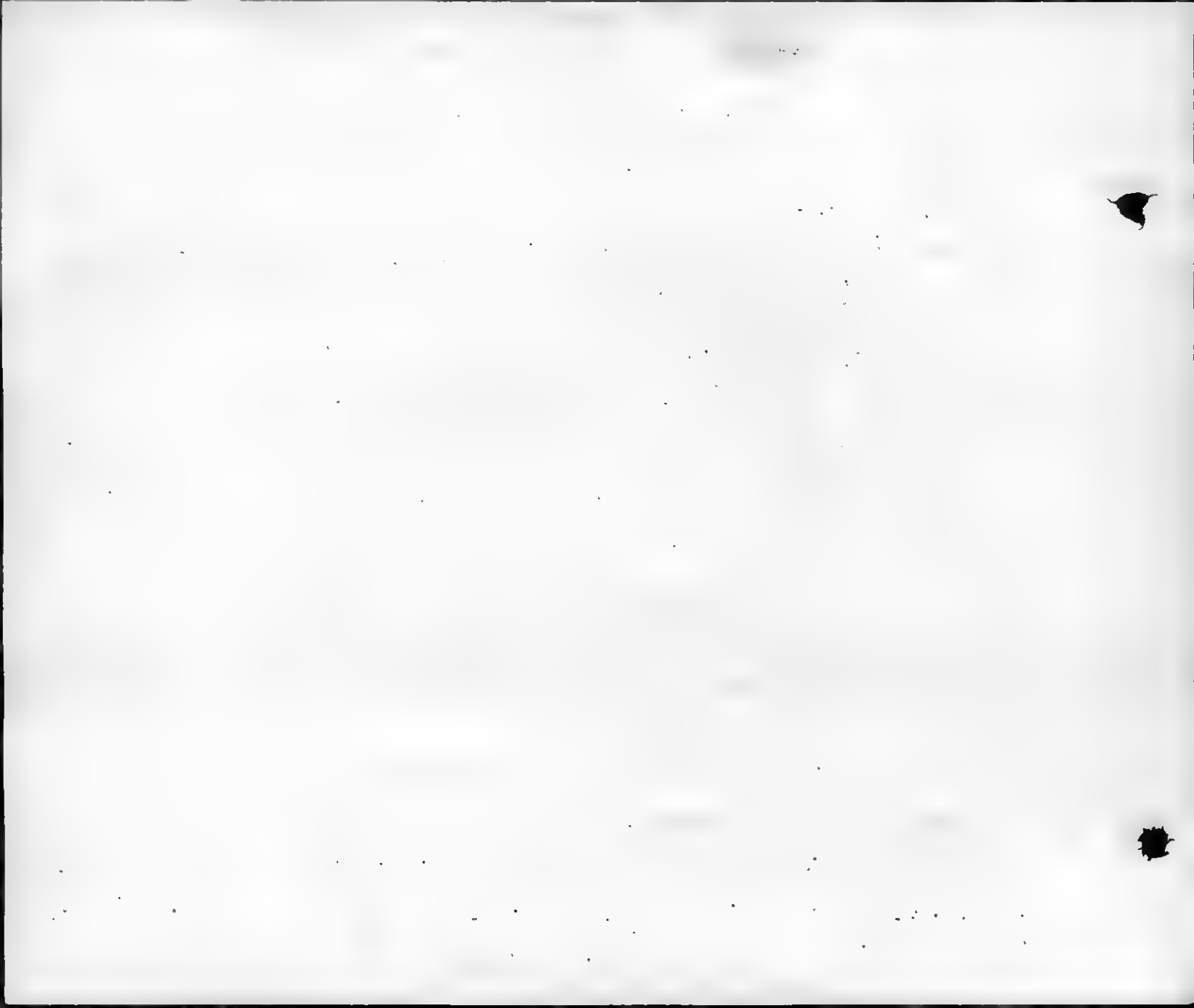
ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE Leon R. Levitsky M.D.

PHYSICIAN'S NAME (Type) Leon R. Levitsky 3408-Rhode Island Ave. Mt. Rainier, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 28/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Valley's Funeral Home</u>		24a. REC'D BY REGISTRAR <u>Jan 30 61</u>	24b. REGISTRAR'S SIGNATURE <u>James A. Hanna</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



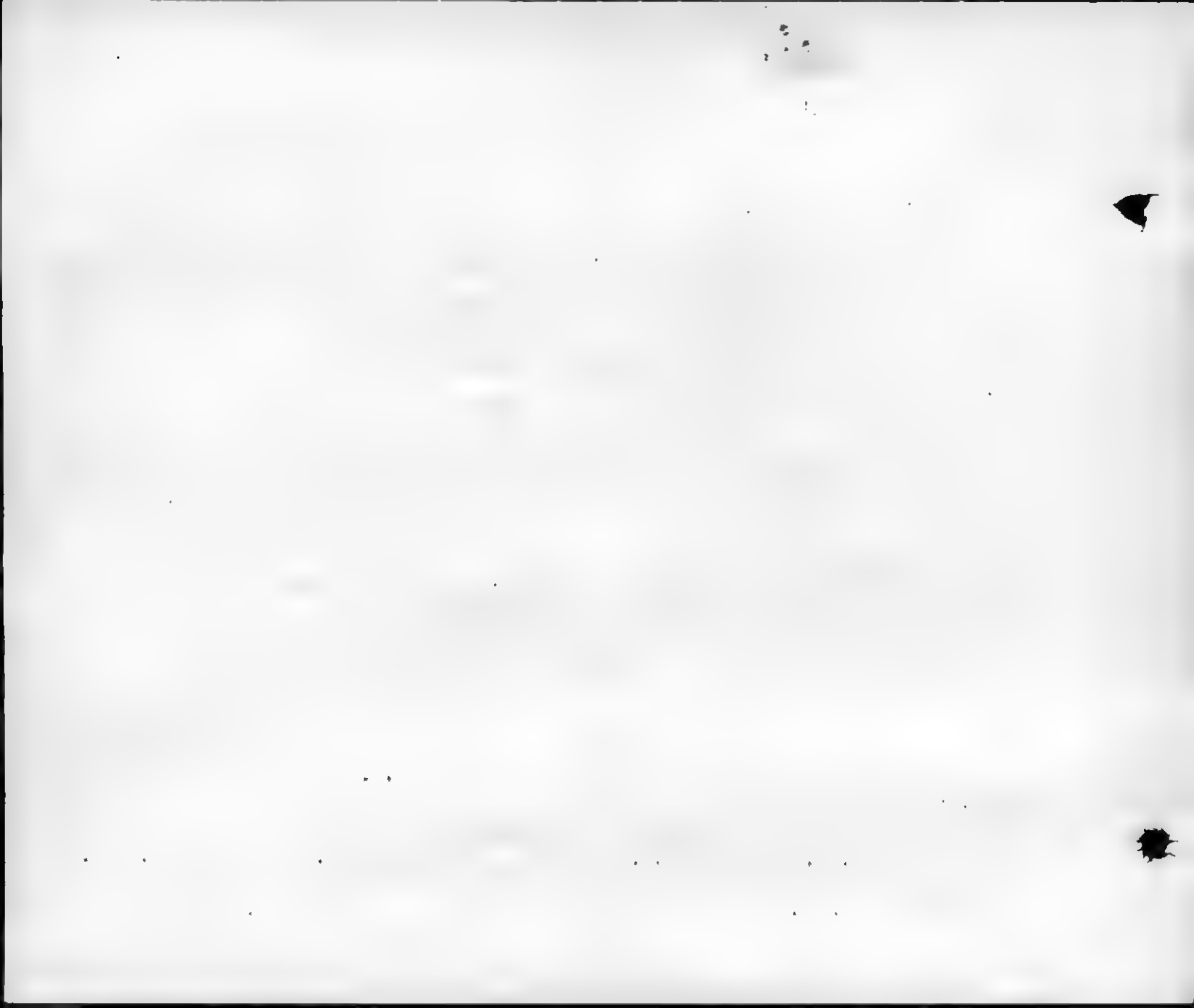
TO HOSPITAL: The low requires that the death certificate be executed with n 24 hours after death. Page 4
 TO ATTENDING PHYSICIAN: The low requires that the death certificate be executed with n 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove portion papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/59

1053
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

(19)43

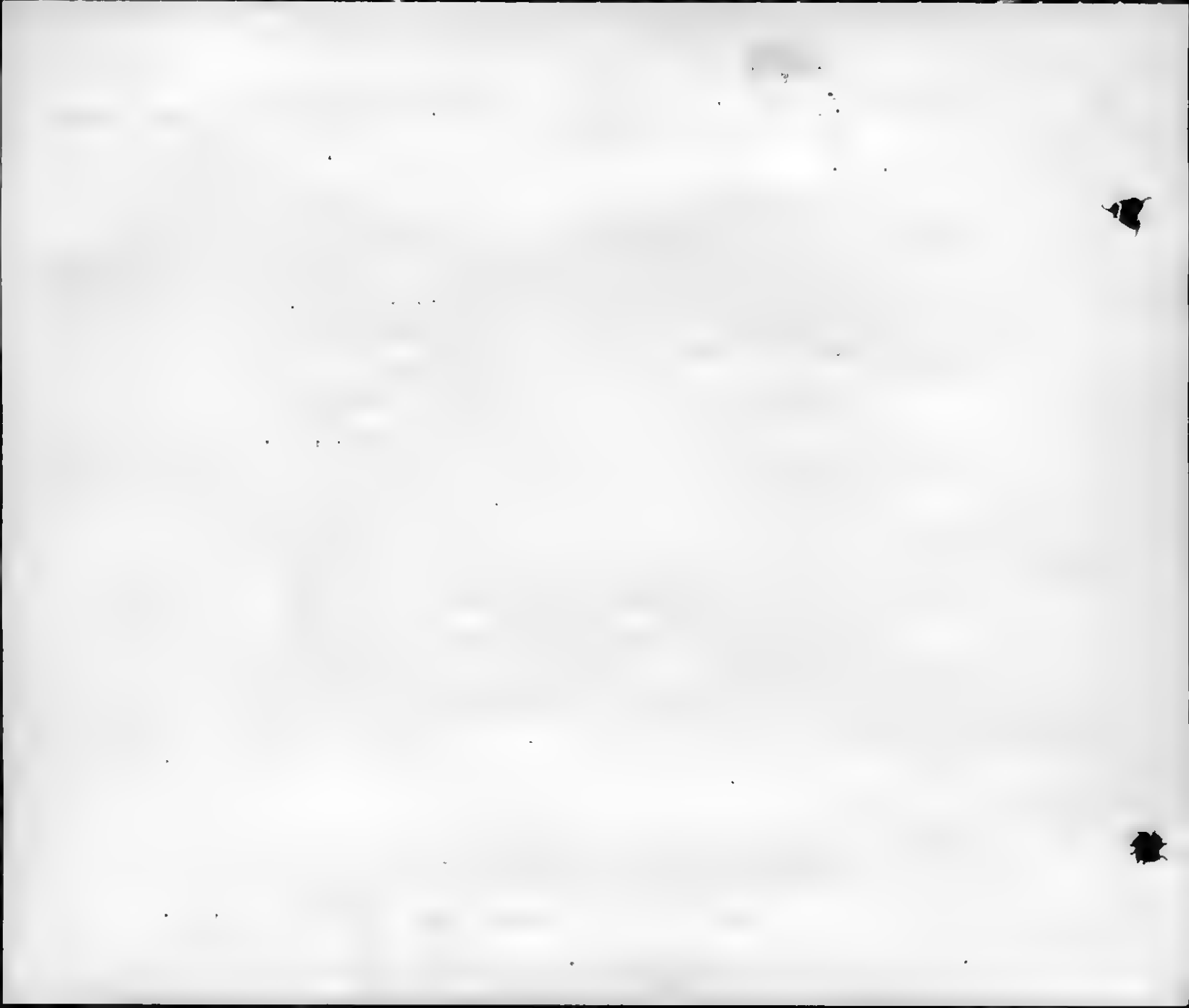
1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN lb 17 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				d. STREET ADDRESS 506 75th Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Earl J. Munyon				4. DATE OF DEATH Month Day Year January 13 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-4-02	
9. AGE (n years last birthday) 58 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARE OF ENGINEERS U.S. GOVT.				10b. KIND OF BUSINESS OR INDUSTRY NEW JERSEY			
11. BIRTHPLACE (State or foreign country) NEW JERSEY				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME EDWARD J. MUNYON				14. MOTHER'S MAIDEN NAME MARY MORGAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT ELLA MUNYON 506.75th ST. CARMODY HILLS				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho pneumonia 420.0 DUE TO (b) Myocardial infarction Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. from left ventricle DUE TO (c) hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from NOV-1960 to JAN-13 1961 that (I) (we) last saw the deceased alive on 1-13 1961 , and that death occurred 6:08 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Max M. Herzberg				22b. DATE SIGNED 1-14-1961			
22c. PHYSICIAN'S NAME (Type) Dr. M. Herzberg M.D.				22d. ADDRESS 7016 Greigg St. Seat Pleasant., Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1.18.1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland. Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE 3004 ST. N. W. W. H. S. C.				25a. REC'D BY REGISTRAR JAN 19 61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



1034

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie, Md.		c. LENGTH OF STAY IN 1b Bowie, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 122 11th street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Claude Middle Everett Last Noble		4. DATE OF DEATH Month 1 Day 5 Year 1961	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 23, 1899
9. AGE (In years last birthday) 61 yrs		10. IF UNDER 1 YEAR Months 1 Days 5 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Tom Noble		14. MOTHER'S MAIDEN NAME Annie ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Cora Noble		Address Bowie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 47 yr. Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Coronary Sclerosis DUE TO 3 yrs. (c) Arteriosclerosis, genl. 15 yrs.		INTERVAL BETWEEN ONSET AND DEATH 3 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a)) Peripheral Nerveitis		19. WAS A TUPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 11 a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/4 1945 , to 1/5 1961 , that (I) (we) last saw the deceased alive on 1/4 1961 , and that death occurred at 12:35 AM, from the causes and on the date stated above.			
22a. SIGNATURE J. M. Warren M.D.		22b. DATE SIGNED 1/5/61	
22c. PHYSICIAN'S NAME (Type) J. M. Warren		22d. ADDRESS LAUREL, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 7, 1961	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons		25a. REC'D BY REGISTRAR JAN 9 '61	
ADDRESS Hyattsville, Md.		25b. REGISTRAR'S SIGNATURE Charles E. Kenna	

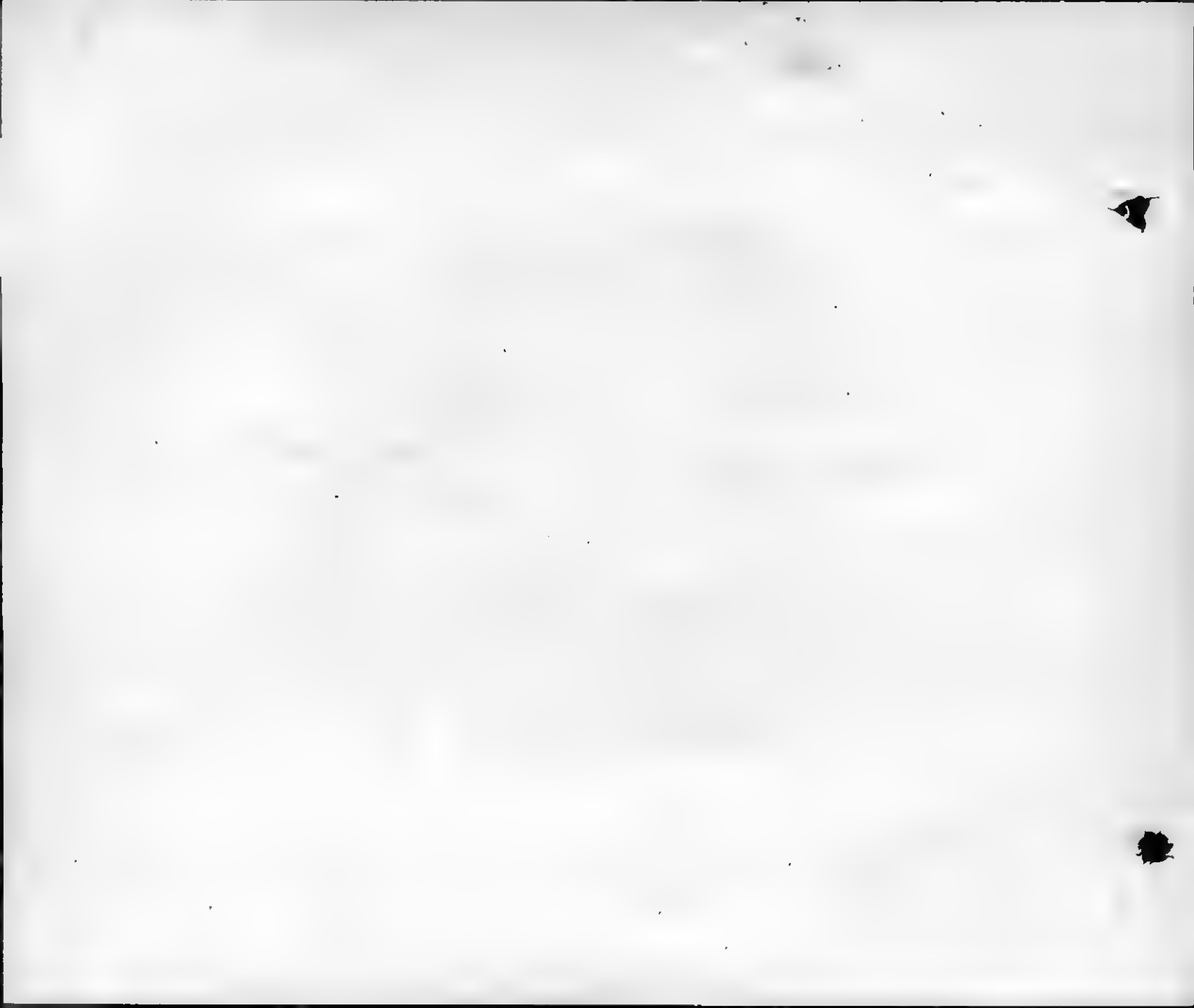


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or in any event, within 72 hours after death.

1055

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Elizabeth's Hospital</u>		d. STREET ADDRESS <u>5809 Taylor Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Earl</u> Middle <u>Leonard</u> Last <u>Norton</u>		4. DATE OF DEATH January 12 1961	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 31 - 1914</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Methods Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Chicago, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>James Albert</u>		14. MOTHER'S MAIDEN NAME <u>Kidwell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Ethel Mary Norton - Wife</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u>Arteriosclerotic heart disease</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>5 yrs</u>		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-8</u> to <u>1-12</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-11</u> , 19 <u>61</u> , and that death occurred at <u>11 P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John P. Clum</u>		22b. DATE SIGNED <u>1-13-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John P. Clum</u>		22d. ADDRESS <u>6110- 43rd Ave Hyattsville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL, DISPOSITION <u>XXXXXX</u>	23b. DATE THEREOF <u>1-16-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Colmor Manor, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. L. L. L.</u> ADDRESS <u>3004 N. 15th St.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 16 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>



61046

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, give address) a. STATE <u>MD</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>HYATTSVILLE COMMUNESCENT HOME</u>		e. STREET ADDRESS <u>4213-31ST ST</u>	
3. NAME OF DECEASED (Type or print) First <u>ETHEL</u> Middle <u>PATTERSON</u> Last <u>PATTERSON</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 27, 1874</u>
9. AGE (In years last birthday) <u>86</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD M. C. BOTTERILL</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE JOHNSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>JAN PATTERSON</u>		Address <u>MT RAINIER MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/2</u> 19 <u>57</u> to <u>1/30</u> 19 <u>61</u> , that I lost saw the deceased alive on <u>5/5</u> 19 <u>60</u> , and that death occurred at <u>5:30</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Donald Doman</u> M.D.		ADDRESS (Street, city or town, state) <u>3503 Penny St</u>	
DATE SIGNED <u>1/30/61</u>		PHYSICIAN'S NAME (Type) <u>WILLIAM DONALD DOMAN</u> <u>MT RAINIER MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		24. REGISTRAR'S SIGNATURE	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

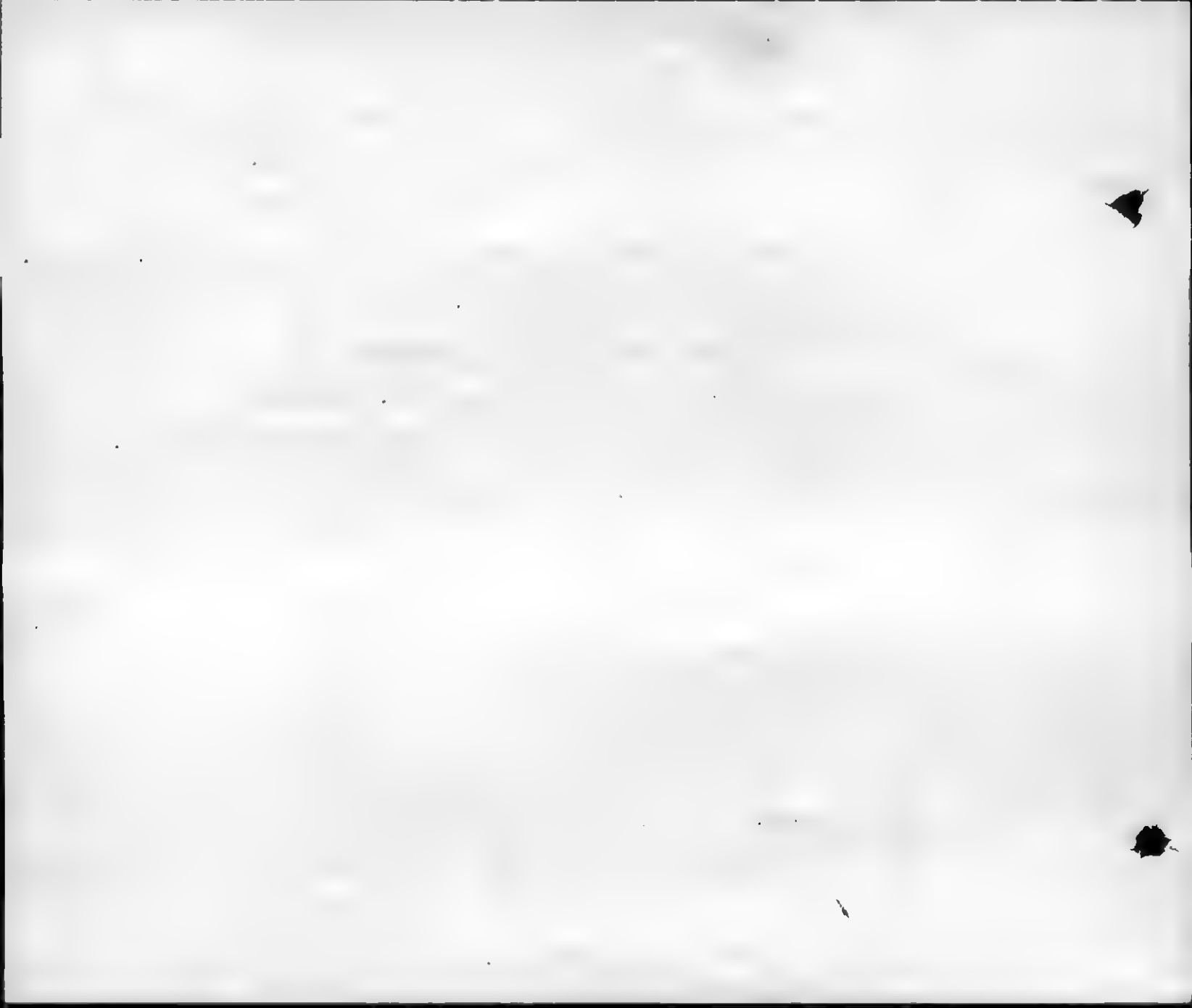
1057

1

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

61047

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Res dence before admission) a. STATE Maryland b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly Md				c. LENGTH OF STAY IN 1b D O A			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. STREET ADDRESS 6915 Quincy Street			
3. NAME OF DECEASED (Type or print) First James Middle Joseph Last Patterson				4. DATE OF DEATH Month January Day 19 Year 19 61.			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 14, 1905	
9. AGE (In years last birthday) 55 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Budget Analyst				10b. KIND OF BUSINESS OR INDUSTRY Dept of Defence		11. BIRTHPLACE (State or foreign country) Washington D C	
12. CITIZEN OF WHAT COUNTRY? U S A							
13. FATHER'S NAME Thomas F Patterson Sr				14. MOTHER'S MAIDEN NAME Margaret M. Patterson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578 14 2621		17. INFORMANT Rose A Patterson Address Radiant Valley Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ATHEROSCLEROTIC HEART DISEASE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) NONE						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/6 19 61 , to 1/19 19 61 , that (I) (we) last saw the deceased alive on 1/19 19 61 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE C. James Duke				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/20/61	
22c. PHYSICIAN'S NAME (Type) C. JAMES DUKE				22d. ADDRESS 6607 RIVERDALE RD, RIVERDALE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/23/61		23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Washington D C	
24. FUNERAL DIRECTOR'S SIGNATURE F Gasch's Sons				ADDRESS Hyattsville, Maryland.		25a. REC'D BY REGISTRAR DATE JAN 24 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1058

CERTIFICATE OF DEATH

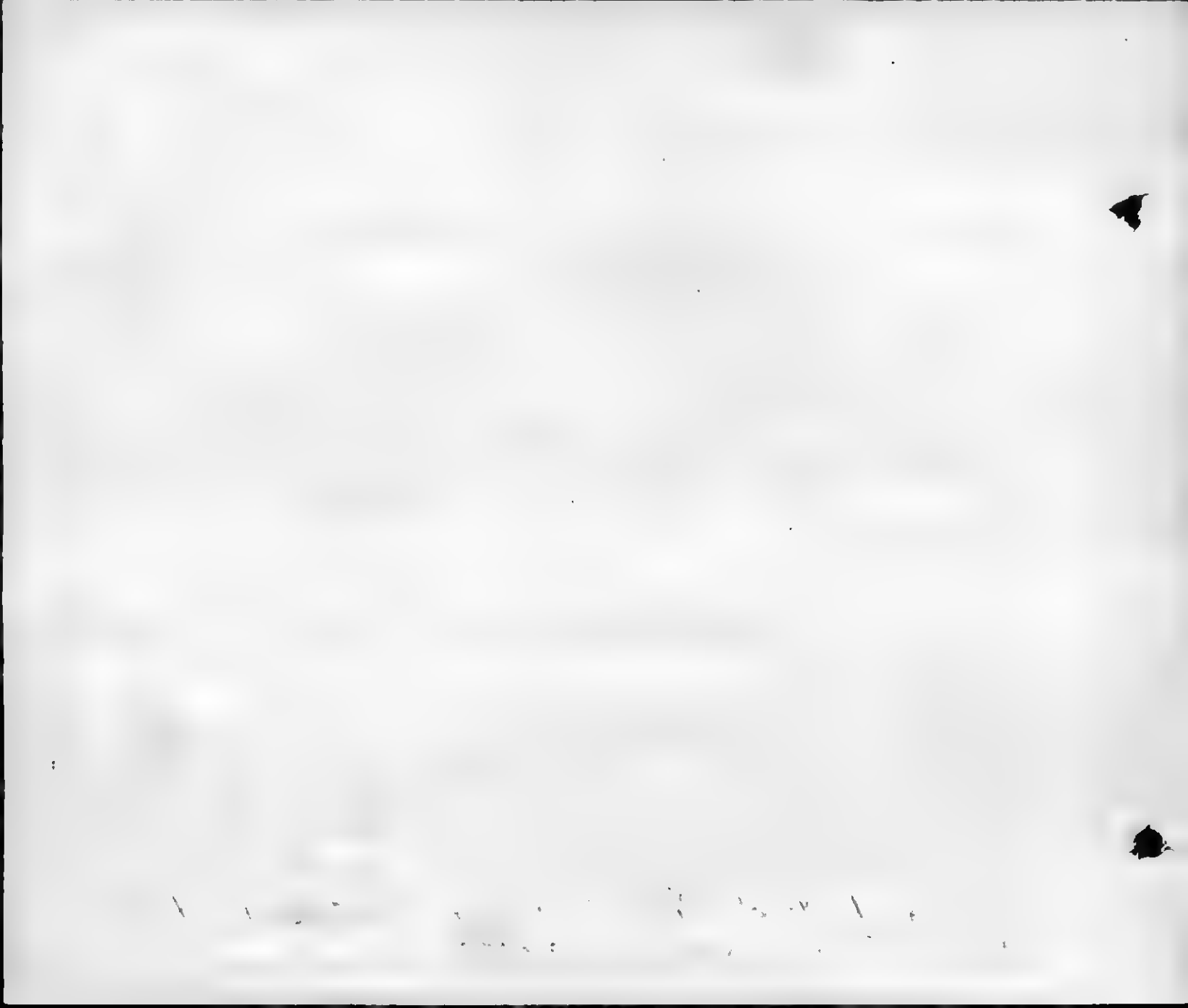
Reg. Dist. No.

62028

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accokeek</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>Susan</u> Last <u>Penn</u>				4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1888</u>		9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Piscataway Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Sidney Pickeral</u>				14. MOTHER'S MAIDEN NAME <u>Emma Pickeral</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Wallace C Penn 109 Stark Rd, Indian Head Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma Uterus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> to <u>1/6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1/5</u> , 19 <u>61</u> , and that death occurred at <u>10:55 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>5 Indian Head Ave</u> DATE SIGNED <u>1/6/61</u>							
ACTUAL SIGNATURE <u>Frank G. Quisenberry</u> M.D.				DATE SIGNED <u>1/6/61</u>			
PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>				ADDRESS <u>Indian Head Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-9-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>		22d. LOCATION (City, town, or county) (State) <u>Accokeek, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf Md</u>				24a. REC'D BY REGISTRAR <u>DATE JAN 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Penn</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
1059 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Prince George's. MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Price George's.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 42-B Ridge Road			d. STREET ADDRESS 42-B Ridge Road		
3. NAME OF (Type or print) JAMES First EDWARD Middle PORTER Last			4. DATE OF DEATH Jan. 21, 1961 Month Day Year		
5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH May 3, 1903		
9. AGE (In years last birthday) 57 yrs.			10. IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Merchant		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME James Porter			14. MOTHER'S MAIDEN NAME Ella Barry		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. John Foley			Address #2 E. Westway, Greenbelt, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hemorrhage and shock from gunshot wound of head PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY (a) OR CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Shot self in right temple 20c. TIME OF INJURY Month, Day, Year 11:00 a.m. 1-21-1961 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) (County) (State) Greenbelt Pz. Md					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Jan. 21, 1961 Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF Jan. 24/61		22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Washington D. C.	
23. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.					
24a. REC'D BY REGISTRAR JAN 24 '61					
24b. REGISTRAR'S SIGNATURE Arthur S. Kram					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1060

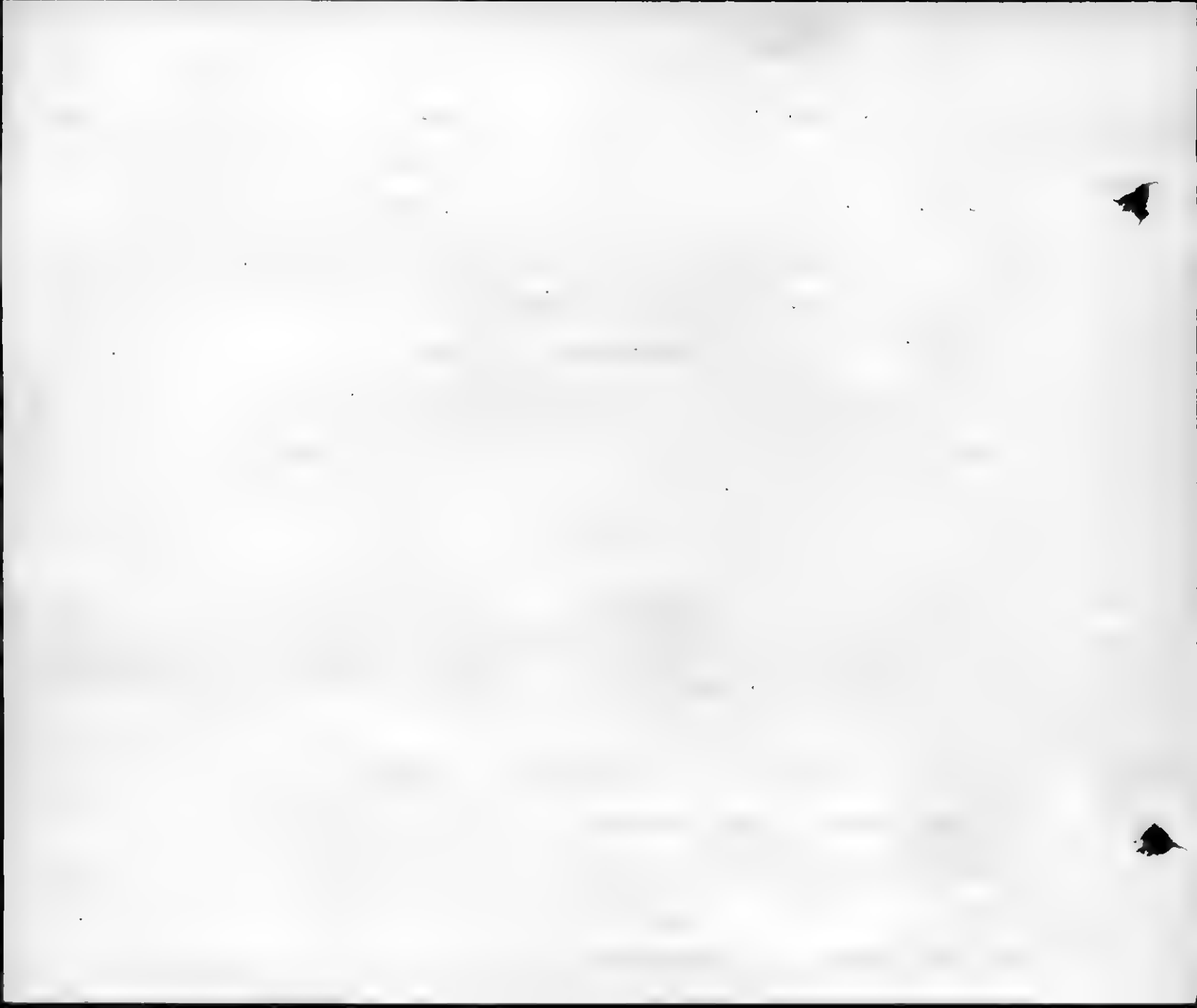
CERTIFICATE OF DEATH

Reg. Dist. No.

61050

1 PLACE OF DEATH a. COUNTY Prince George MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greenbelt				c. LENGTH OF STAY IN 1b Greenbelt			
d. NAME OF HOSPITAL (If not in hospital, give street address) 59 F. Ridge Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ruth		First K.		Middle Pugh		Last Jan.	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 27, 1899	
9. AGE (In years lost birthday) 61		10. UNDER 1 YEAR Months Days		11. UNDER 24 HRS Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Indiana	
13. FATHER'S NAME William Kerhin				14. MOTHER'S MAIDEN NAME Emma Pipsenberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. INFORMANT Lewis M. Pugh Same as #2 (Husband)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism acute 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial heart disease DUE TO (c) 2 years							INTERVAL BETWEEN ONSET AND DEATH 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1950 , 19 to Jan 24 , 1961 that I last saw the deceased alive on Jan 18 , 1961, and that death occurred at 10 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest E. Cornelsen M.D. 4400 Bonaparte St				DATE SIGNED 1-26-61			
PHYSICIAN'S NAME (Type) ERNEST E. CORNELSEN MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/61		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Suitland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F. Gasch's Sons				ADDRESS Hyattsville, Md.		24a. REC'D BY REGISTRAR HAN 3 0 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline							

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

C1051

1061

1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE DISTRICT OF COLUMBIA c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAUREL		c. LENGTH OF STAY IN lb adm. 8-27-1957	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION LAUREL SANITARIUM		d. STREET ADDRESS 1221 MASS. Ave N.W.	
3. NAME OF DECEASED (Type or print) First MARY Middle B. Last RANDOLPH		4. DATE OF DEATH Month JANUARY Day 10 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT-3-1866
9. AGE (In years last birthday) 94 yrs.		10. IF UNDER 1 YEAR Months 94 Days 94 Hours 94 Min 94	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOAN GEORGE BUDERER		14. MOTHER'S MAIDEN NAME ELISABETH KIEFER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unknown		16. SOCIAL SECURITY NO none	
17. INFORMANT Hosp. Records LAUREL SANITARIUM		Address LAUREL SANITARIUM	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 49K DUE TO Bronchopneumonia (49i) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) DUE TO a week ago (c) DUE TO a week ago		INTERVAL BETWEEN ONSET AND DEATH a week ago	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis with dementia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 27 , 19 57 , to Jan 10 , 19 61 , that I last saw the deceased alive on January 10 , 19 61 , and that death occurred at 10:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Erika P. Kraemer		DATE SIGNED 1-10-61	
PHYSICIAN'S NAME (Type) ERIKA P. KRAEMER		LAUREL MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-13-1961	22c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	22d. LOCATION (City, town, or county) (State) SUITLAND, MD
23. FUNERAL DIRECTOR'S SIGNATURE Joseph G. Lewis		24a. REC'D BY REGISTRAR Wash. D.C.	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume		DATE JAN 13 '61	

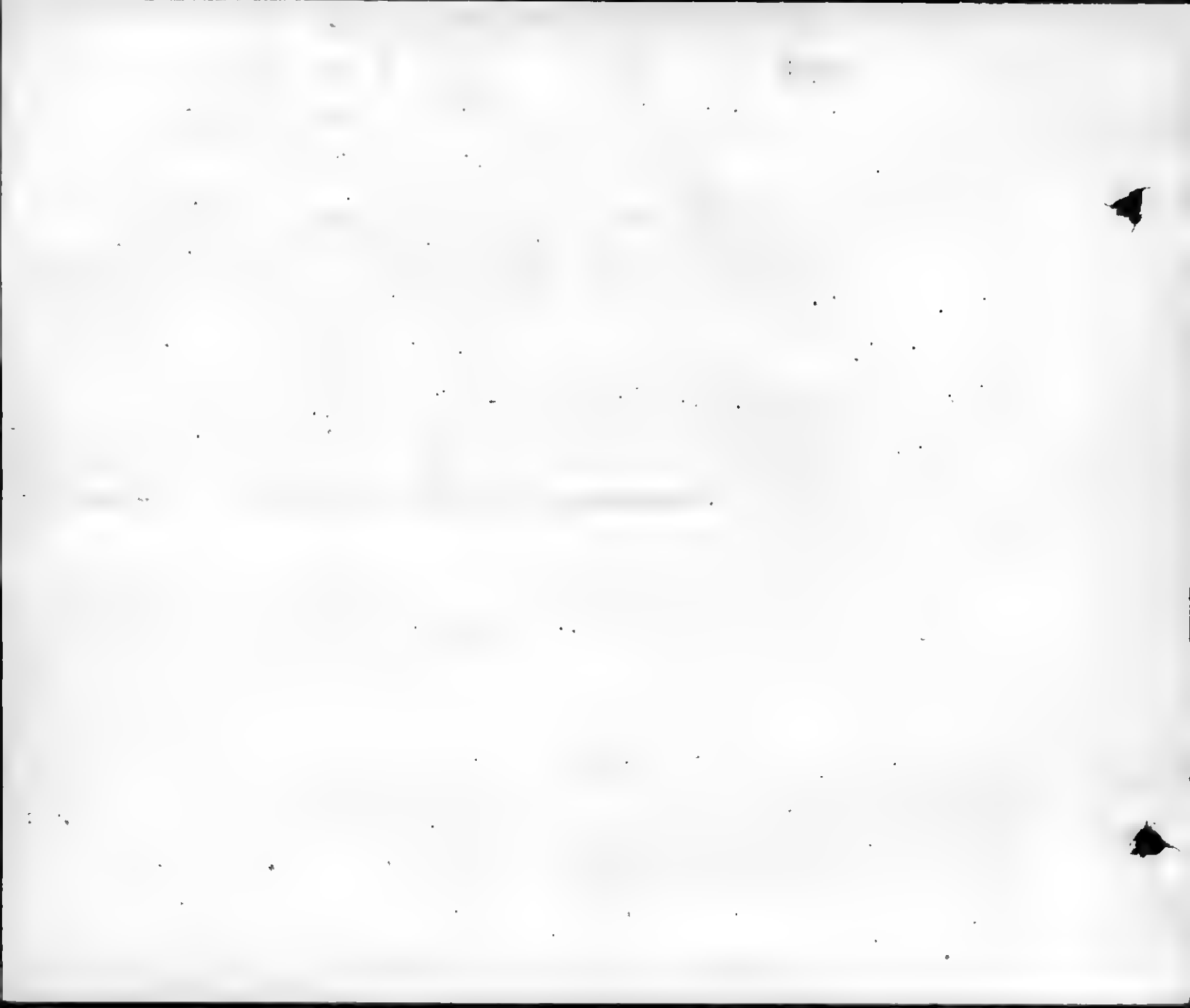
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1062

Item 8 **CERTIFICATE OF DEATH**

1052

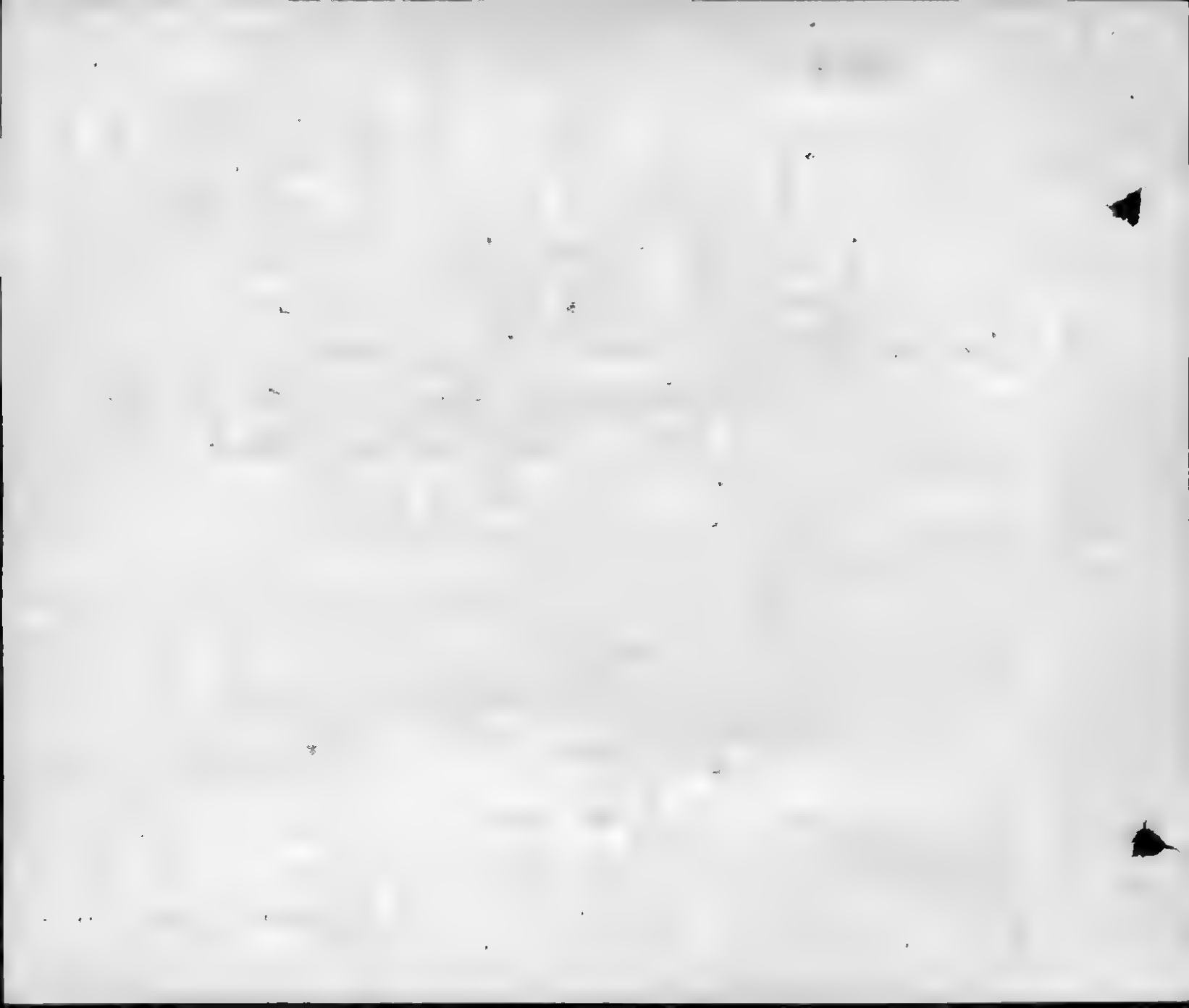
1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 72 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Capitol Heights	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				d. STREET ADDRESS 404 59th Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle REED Last Rawlings				4. DATE OF DEATH Month Jan Day 14 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1895 23 Mar. 1895	
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min 1		11. IF UNDER 24 HRS Months 1 Days 1 Hours 1 Min 1		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Taxi Cab driver				10b. KIND OF BUSINESS OR INDUSTRY Black-White Cab		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Unknown				14. MOTHER'S MARDEN NAME Sarah Duley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-01-4087		17. INFORMANT Ruth B. Miller Address 1-B Southway Humboldt Md!			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 months 2 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Capitol Heights Md	
20f. (City or town) Capitol Heights Md				20g. (County) Prince Georges			
20h. (State) Maryland				20i. (City or town) Capitol Heights Md			
21. I certify that (I) (this hospital) attended the deceased from 1/13 19 60 , to 1/14 19 61 , that (I) (we) last saw the deceased alive on 1/14 19 61 , and that death occurred at 3:30 AM from the causes and on the date stated above.							
22a. SIGNATURE William Brainin				22b. DATE SIGNED 1/14/61			
22c. PHYSICIAN'S NAME (Type) WM BRAININ				22d. ADDRESS 6124 Centret Ave, Capitol Heights Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-16-61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co.				ADDRESS 517-11th St. S.E.		25a. REC'D BY REGISTRAR DATE JAN 18 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kline			



VS. A15ME
SM 7/59

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It can be used by the Medical Examiner's Office to request the funeral home to prepare the body for burial or cremation. Please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the Medical Examiner's Office.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department. The body must be prepared for burial or cremation by the funeral director or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

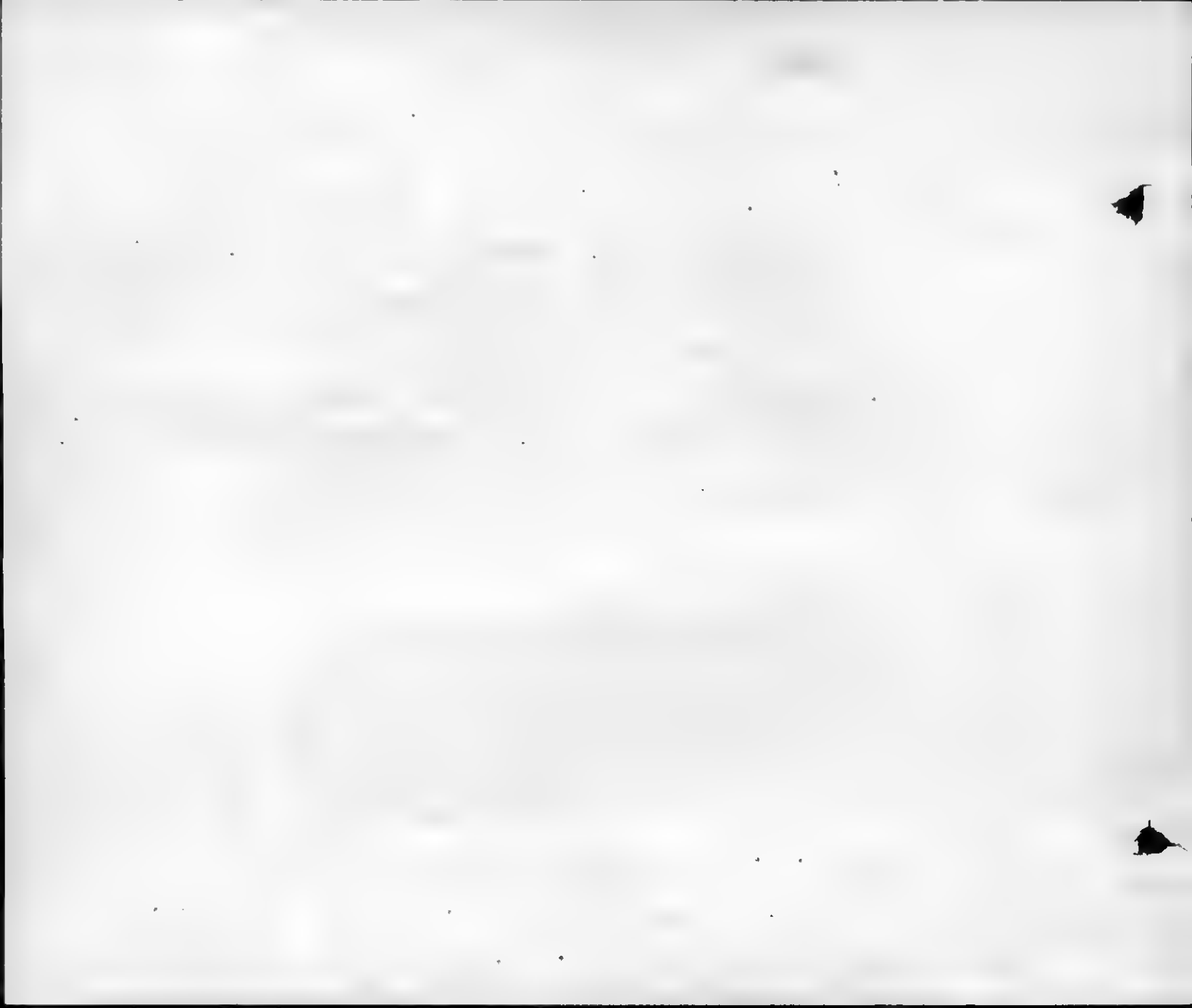
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1064

1.1054

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Md. b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4205 Kennedy St.				d. STREET ADDRESS 4205 Kennedy St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First KATHERINE Middle M. Last REICHENBACH				4. DATE OF DEATH Month Jan. Day 19 Year 1961			
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 22 June 1887		9 AGE (In years last birthday) 73 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Jones				14. MOTHER'S MAIDEN NAME Myra Boswell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. --None		17. INFORMANT Geo. S. Reichenbach Baltimore 12, Md.			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of Colon DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) With Metastases DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 11 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peripheral Vascular Disease						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Feb. 1960 to Jan. 1961 , that (I) (we) last saw the deceased alive on Jan 17 1961 , and that death occurred at 7 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Bernard A. Fitzgerald				22b. DATE SIGNED 1-19-61		22c. PHYSICIAN'S NAME (Type) Bernad. A. Fitzgerald	
22d. ADDRESS 217 University Blvd E. S. D. Md.							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 23 Jan. 1961		23c. NAME OF CEMETERY OR CREMATORY Congressional Cem.		23d. LOCATION (City, town, or county) (State) Washington, D.C.	
24 FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home 300-4th St. N.E. D.C.				25a. REC'D BY REGISTRAR JAN 24 '61		25b. REGISTRAR'S SIGNATURE Curtis S. Evans	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

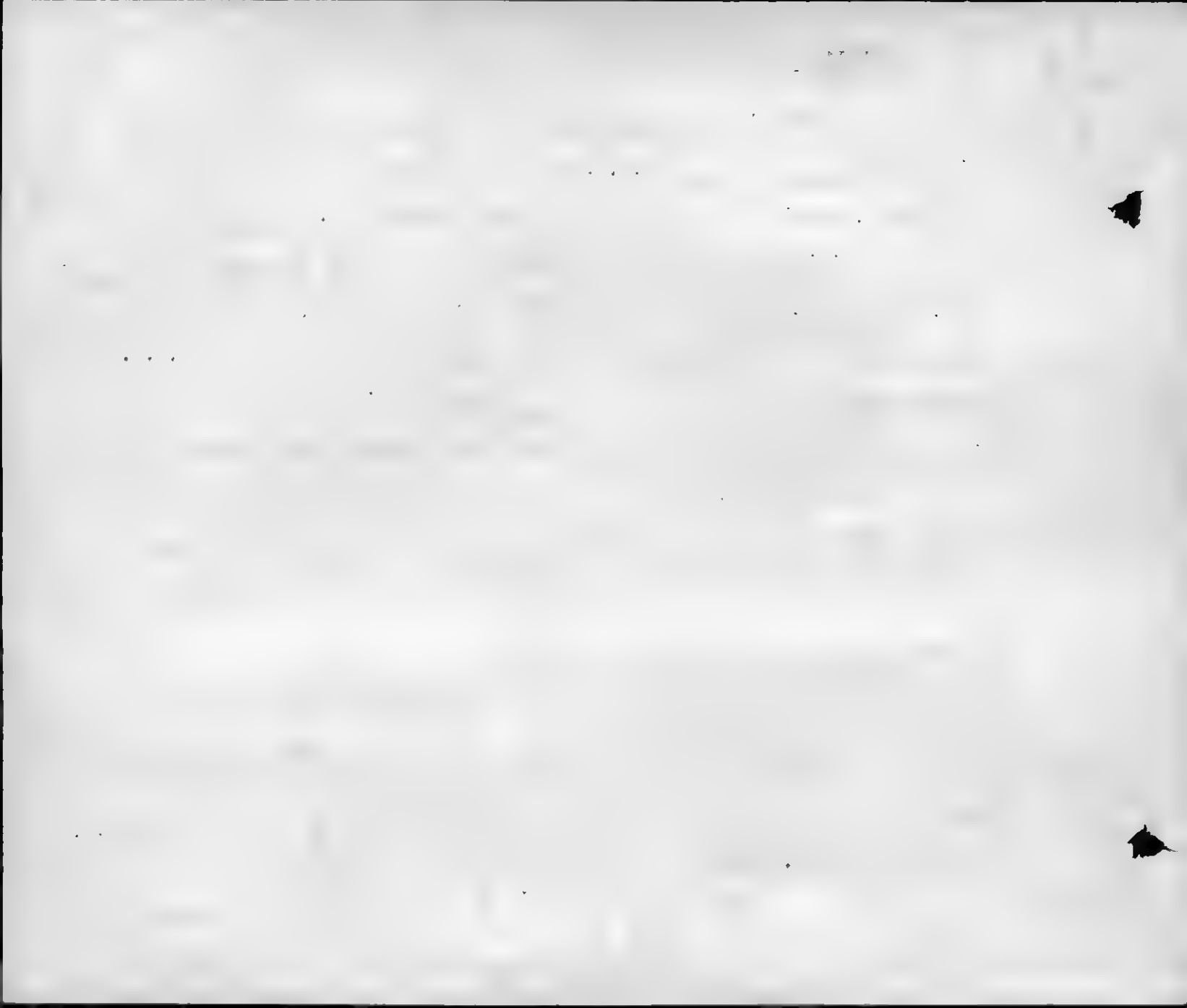
1065 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1055

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. IF FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Prince George's</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Leland Mem. Hospital</u>				d. STREET ADDRESS <u>4504 Sheridan St.</u>			
3. NAME OF DECEASED (Type or print) <u>Meriam Dorothy RIDENOUR</u>		4. DATE OF DEATH <u>January 19 1961</u>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>28 March 1917</u>	9. AGE (In years last birthday) <u>43</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own House</u>		11. BIRTHPLACE (State or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harold Arendt</u>				14. MOTHER'S MAIDEN NAME <u>Mabel Gavitts</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>*****</u>		17. INFORMANT <u>Paul Ridenour (Husband)</u> Address <u>same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>270x</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>270x</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>James I. Boyd</u>		DATE SIGNED <u>1/19/1961</u>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-23-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>	24a. REC'D BY REGISTRAR <u>W.W. Chambers & Co. Riverdale, Md.</u>			
23. FUNERAL DIRECTOR <u>W.W. Chambers & Co. Riverdale, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		DATE <u>JAN 25 '61</u>			



1066

CERTIFICATE OF DEATH

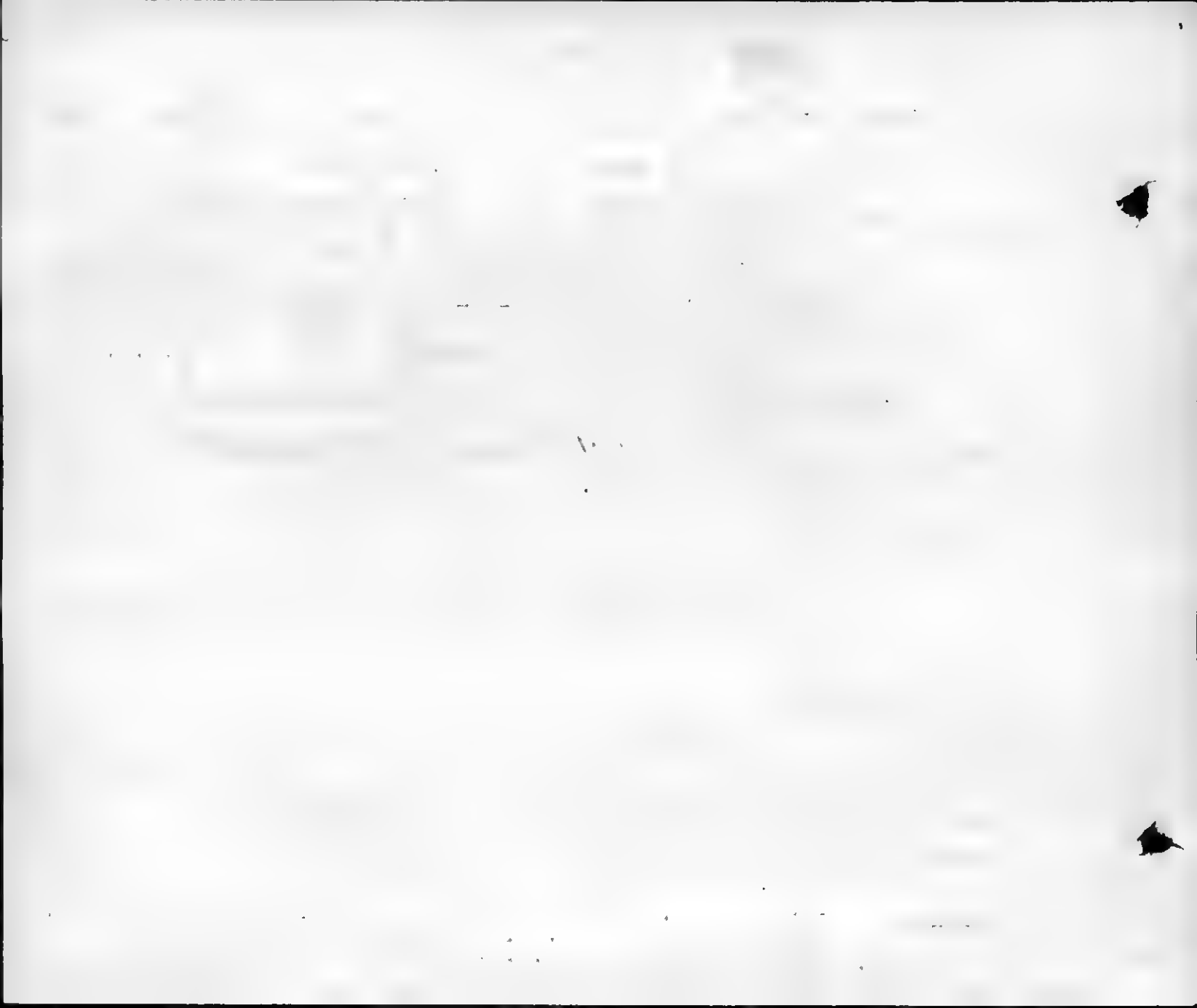
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CITRIVILLE</u>				c. LENGTH OF STAY IN TB <u>5</u> years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ad-Sarcoda Nursing Home</u> <u>2601 CLEVELY AVENUE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mrs Mary C. Ryan</u>				4. DATE OF DEATH Month Day Year <u>JAN 6 1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-17-78</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>FRANK B. LISS</u>				14. MOTHER'S MAIDEN NAME <u>HARRIET BURGESS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>579-10-7521</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>GENERAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>10 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>1/9</u> , 19 <u>60</u> , to <u>1/6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1/6</u> , 19 <u>61</u> and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Norman Donat Bmeau</u> M.D.				ADDRESS (Street, city or town, state) <u>3503 Perry St. MT Rainier Md</u>			
DATE SIGNED <u>1/6/61</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>1-9-61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET CEMETERY</u>			
22d. LOCATION (City, town, or county) <u>WASHINGTON</u> (State) <u>D. C.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>F. J. Collins</u> ADDRESS <u>WASH. D.C. 3821 14TH. ST. N.W.</u>			
24a. REC'D BY REGISTRAR <u>JAN 10 1961</u>				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



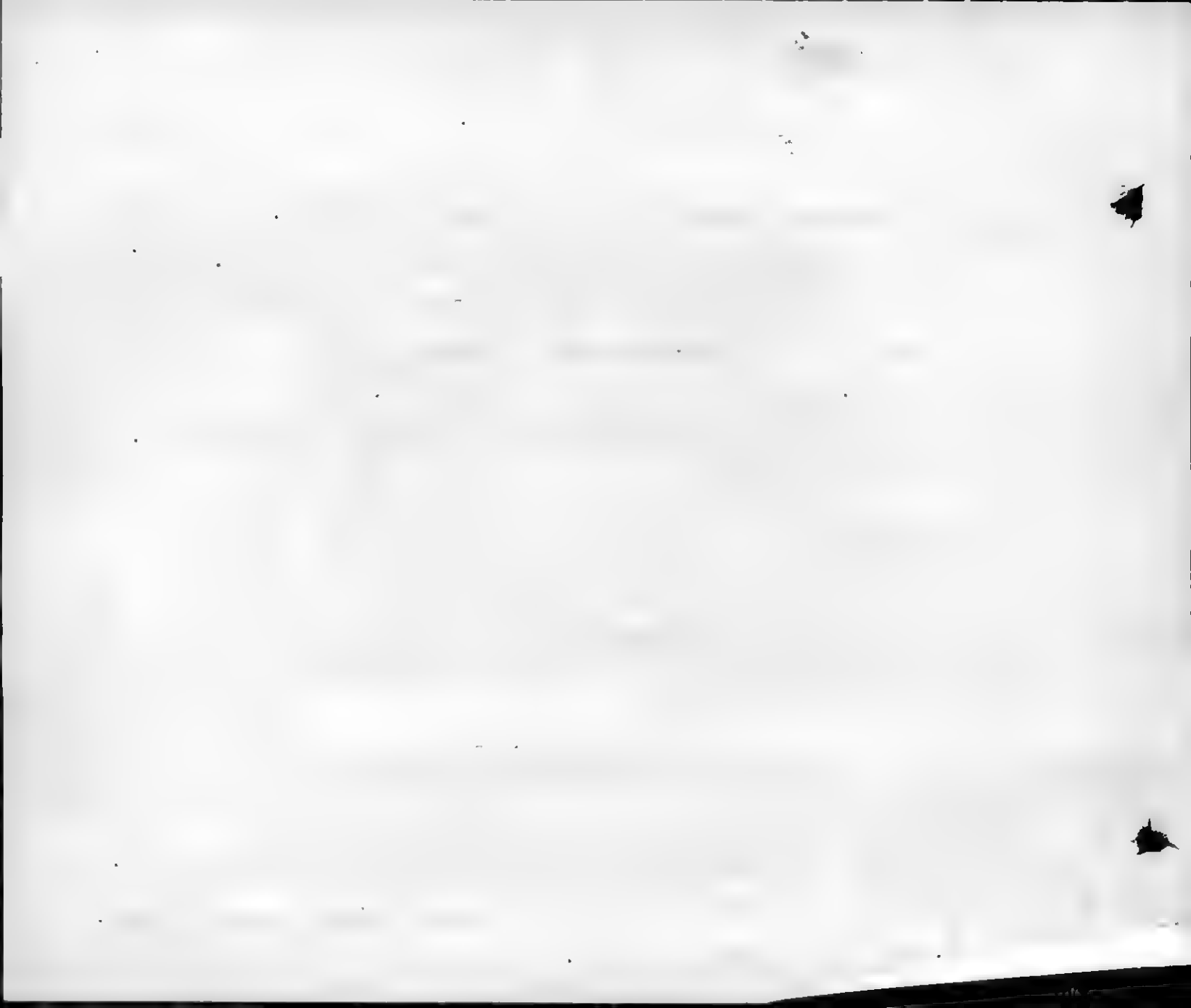
CERTIFICATE OF DEATH

(105)

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

LSR A15 (4)
VSM 92/50



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02270

1068

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVERLY</u>			
c. LENGTH OF STAY IN 1b <u>11 yrs.</u>				d. STREET ADDRESS <u>5798-CARLYLE ST.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5798-CARLYLE ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>B.</u> Last <u>SAUTER</u>				4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 7, 1880</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WASH D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CASPER SAUTER</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE WOODS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-18-0490</u>			
17. INFORMANT <u>CATHY CUNNINGHAM</u>				Address <u>5798-CARLYLE ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/25</u> , 19 <u>61</u> , to <u>1/31</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1/30</u> , 19 <u>61</u> , and that death occurred at <u>4:00</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6480-N. H. AVE</u> DATE SIGNED <u>1/31/61</u> ACTUAL SIGNATURE <u>R. C. Kirchner</u> M.D. <u>TAKOMA PARK MD</u> PHYSICIAN'S NAME (Type) <u>R. C. KIRCHNER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-4-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington DC</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thurman Haulon</u> ADDRESS <u>3831-So Ave NW</u>				24a. REC'D BY REGISTRAR <u>FEB 17 '61</u> DATE		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-28-61 Film 279

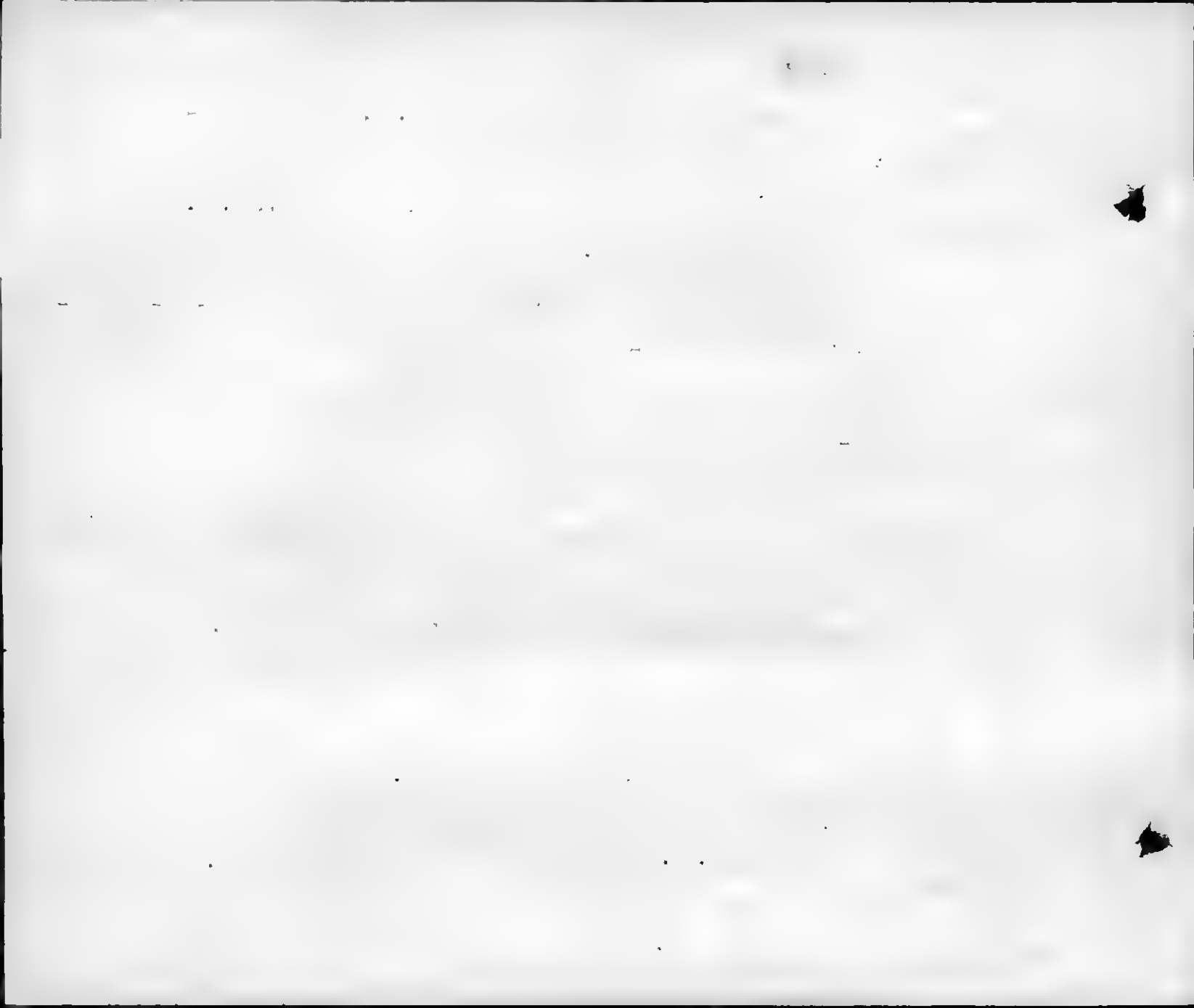
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1069

CERTIFICATE OF DEATH

11058

1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenn Dale Hospital				d. STREET ADDRESS 2409 12th St., N. E.			
3. NAME OF DECEASED (Type or print) First Middle Last French W. Scott				4. DATE OF DEATH Month Day Year 1 8 19 61			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/1890	9. AGE (In years last birthday) 70 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed (unknown)				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Shadrick Scott				14. MOTHER'S MAIDEN NAME Nanie Burross			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Decedent Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 161X DUE TO Postoperative bleeding							1 day
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							Performed 1/5/61
(b) DUE TO Left lower lobectomy for cancer of left lung							
(c) DUE TO Post laryngectomy state for carcinoma of larynx (1959)							
(c) DUE TO Pulmonary tuberculosis, moderately advanced, activity undet							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Post laryngectomy state for carcinoma of larynx (1959) pulm. fibrosis and emphysema							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/16 9:00 AM, to 1/8/ 19 61, that (I) (we) last saw the deceased alive on 1/8/ 19 61 and that death occurred at P. M., from the causes and on the date stated above.							
22a. SIGNATURE Moe Weiss				22b. ADDRESS Glenn Dale Hospital Glenn Dale, Md.		22c. DATE SIGNED 1/8/61	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M. D.				22d. ADDRESS Glenn Dale Hospital Glenn Dale, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) 1/12/61				23b. DATE THEREOF 1/12/61		23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial	
				23d. LOCATION (City, town, or county) MARYLAND		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Capital Funeral Home				25a. REC'D BY REGISTRAR 719 Kennedy Blvd		25b. REGISTRAR'S SIGNATURE DATE JAN 11 '61	



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG279 1-24-61 e

1070

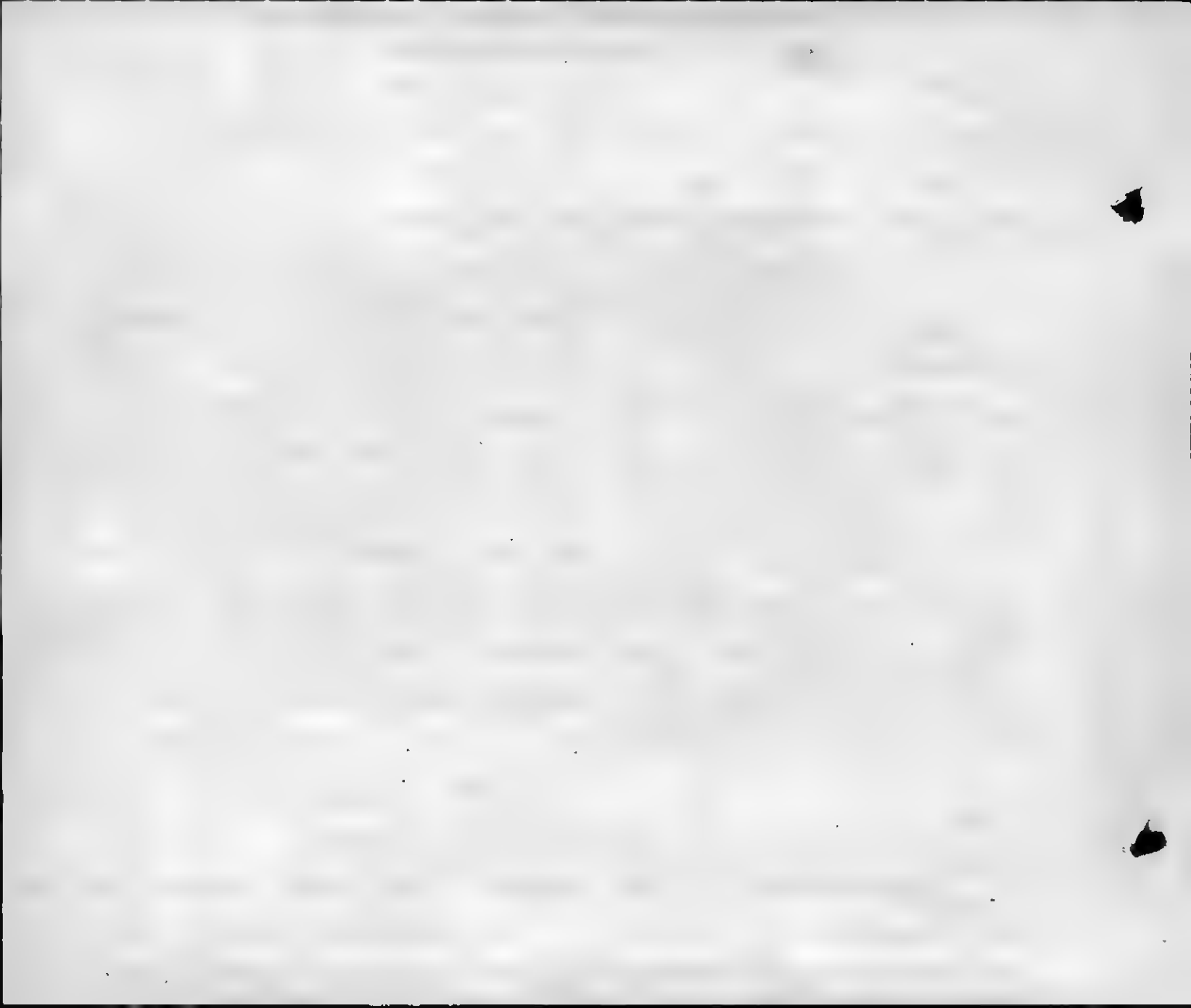
CERTIFICATE OF DEATH

Reg. Dist. No. 1059

1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pri. Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>				c. LENGTH OF STAY IN 1b <u>65 RIVERDALE, MD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>SHARKEY</u> Last <u>SHARKEY</u>				4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1961</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 4, 1873</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>		IF UNDER 24 HRS Hours <u>0</u> Min <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TEXTILE WORKER</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>OWEN SHARKEY</u>				14. MOTHER'S MAIDEN NAME <u>BRIDGET R. SHARKEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>6011-TAYLOR ROAD</u>		17. INFORMANT <u>THOS. S. KANE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO (b) <u>Anteroseptal Heart Disease</u> DUE TO (c) <u>Senility</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>20 yrs</u> <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4955</u> , 19 <u>55</u> , to <u>1961</u> , that I last saw the deceased alive on <u>1/13/61</u> , 19 <u>61</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Gordon W. Kelley</u>				ADDRESS (Street, city or town, state) <u>6124-46th Ave. Hyattsville, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Gordon W. Kelley</u>				DATE SIGNED <u>1/13/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>1/18/61</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Sepulchre</u>		22d. LOCATION (City, town, or county) (State) <u>Philadelphia Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. Staffell</u>				ADDRESS <u>475 H St N.W.</u>		24a. REC'D BY REGISTRAR <u>Jan 16 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Charles E. Kane</u>			

TO HOSPITAL: The attending physician: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



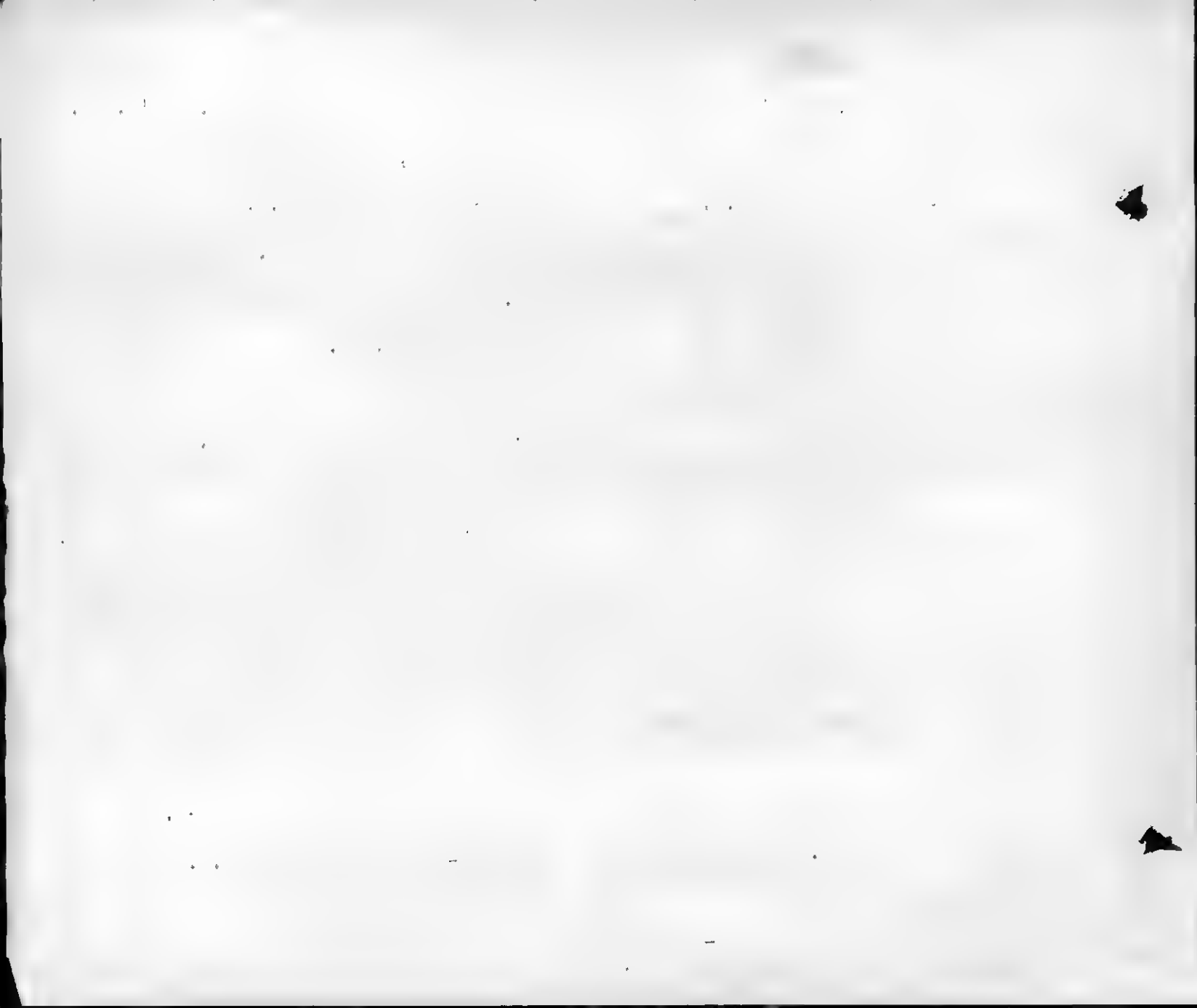
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1071

1060

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxon Hill		c. LENGTH OF STAY IN 1b 45 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5821- Brinkley Road S.E.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last JOHN SAMUEL SHARPER		4 DATE OF DEATH Jan. 6th 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6th 1888
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10b. KIND OF BUSINESS OR INDUSTRY Own	
11. BIRTHPLACE (State or foreign country) Washington, DC.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Sharper		14. MOTHER'S MAIDEN NAME Alice Howard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	
17. INFORMANT Marian Ira Sharper		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 722- Broncho pneumonia DUE TO (b) Chronic Beriberi Deformans 20 yrs DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none of note		INTERVAL BETWEEN ONSET AND DEATH 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) natural cause	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Jan 15 1961 to Jan 6 1961, that (I) (we) last saw the deceased alive on Jan 6 1961 and that death occurred at 5 PM, from the causes and on the date stated above.			
22a. SIGNATURE Paul O. Van Natta		22b. DATE Jan. 6th 61	
22c. PHYSICIAN'S NAME (Type) Paul O. Van Natta		22d. ADDRESS 5440- Silver Hill Road S.E.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 9 - 61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town, or county) (State) Suitland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Simmons Bros.		25a. REC'D BY REGISTRAR DATE JAN 9 '61	
1661 Good Hope Road SE Washington, DC		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1072

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

(1061

1. PLACE OF DEATH a. COUNTY Prince George MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 9 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital		d. STREET ADDRESS 3107 Bunker Hill Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Joseph Middle C. Last Shenk		4. DATE OF DEATH Month January Day 23 Year 1961	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1889
9 AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 61	11. IF UNDER 24 HRS Months 11 Days 19 Hours 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office	
11 BIRTHPLACE (State or foreign country) Annapolis, Pa.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Etter Shenk		14. MOTHER'S MAIDEN NAME Louise Carmany	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. none	
17. INFORMANT Miss Ida Nora Reath		Address 4025-34th St. Mt. Rainier, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive intracerebral hemorrhage, right side 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Hemorrhage into right internal capsule DUE TO (c) Cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH hours Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of the prostate with metastases to bone		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 19, 1961 to Jan. 23, 1961 , that (I) (we) last saw the deceased alive on Jan. 19, 1961 , and that death occurred on Jan. 23, 1961 the causes and on the date stated above.			
22a. SIGNATURE Benjamin S. Miller		22b. DATE SIGNED Jan. 23, 1961	
22c. PHYSICIAN'S NAME (Type) Benjamin S. Miller, M. D.		22d. ADDRESS 3824 34th St., Mt. Rainier, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/27/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Nalley's Funeral Home Inc.		25a. REC'D BY REGISTRAR DATE JAN 30 '61	
25b. REGISTRAR'S SIGNATURE Carlton L. Hume			



1

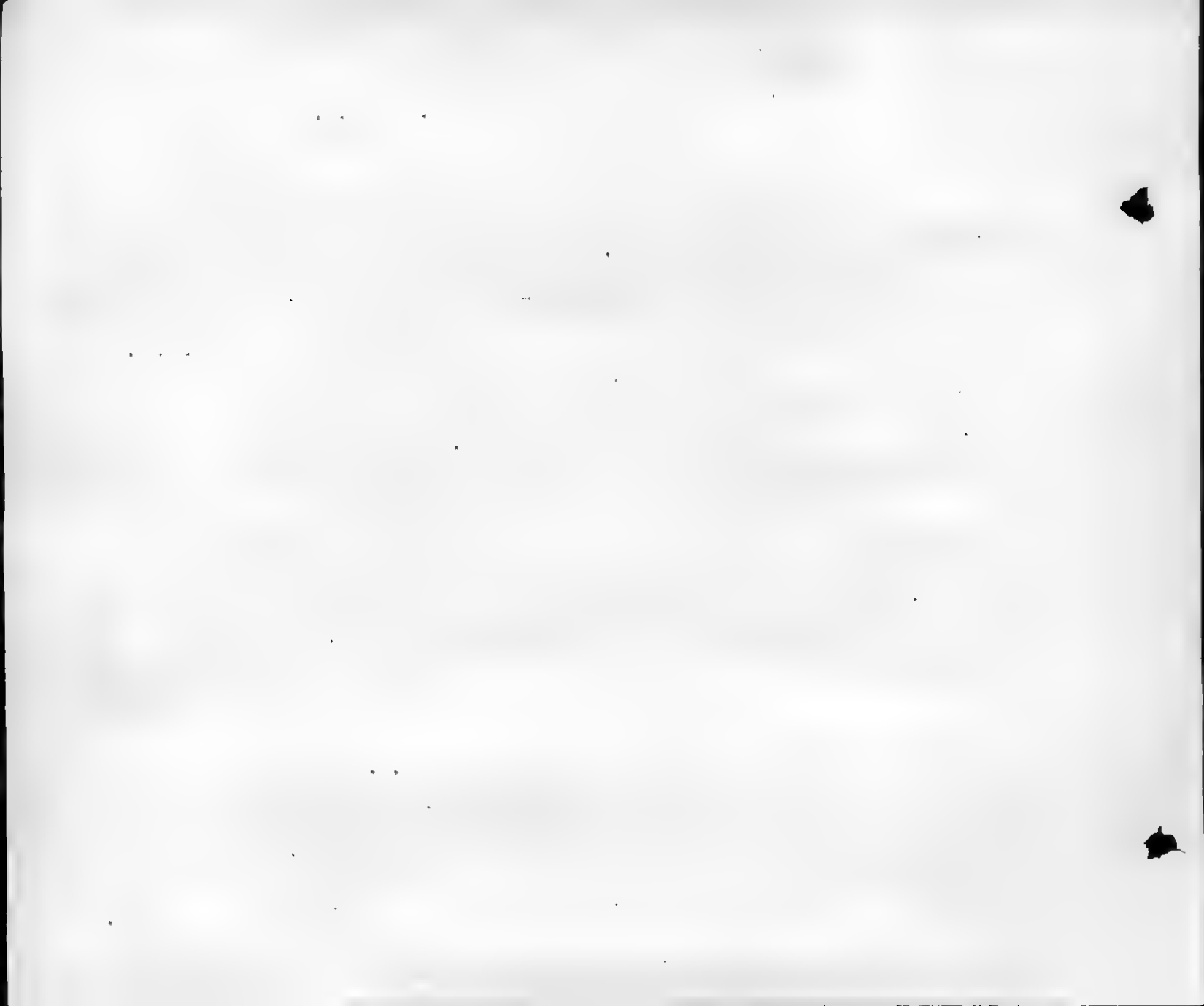
1073

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1306

1. PLACE OF DEATH a. COUNTY Prince George's MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Wash. 28, D.C. b. COUNTY Prince George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 30 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General				d. STREET ADDRESS 6501 Walker Mill Road			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Oakey Middle V. Last Sliger				4. DATE OF DEATH Month January Day 4 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-31-89	
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 1 Hours 1 Min 1		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer				10b. KIND OF BUSINESS OR INDUSTRY Building			
13. FATHER'S NAME Lucian Sliger				14. MOTHER'S MAIDEN NAME Martha (Not Known)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO Not Known		17. INFORMANT Address Robert R. Sliger As Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 4-2-1 IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO Arterio-sclerosis of the heart Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arterio-sclerosis of the heart DUE TO (c) Arterio-sclerosis of the heart				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 1-4				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1-2-61 to 1-4-61 , that (I) (we) last saw the deceased alive on 1-4-61 , and that death occurred at 10:25 P.M. from the causes and on the date stated above.							
22a. SIGNATURE R.D. Bauer, M.D.				22b. DATE SIGNED 1-4-61			
22c. PHYSICIAN'S NAME (Type) R.D. Bauer, M.D.				22d. ADDRESS 473 N. Washington St., Wash. D.C.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/7/1961		23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens		23d. LOCATION (City, town, or county) (State) Arlington Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Princess Funeral Home Falls Church Va.				25a. REC'D BY REGISTRAR DATE JAN 9 '61		25b. REGISTRAR'S SIGNATURE C. L. S. Hanna	



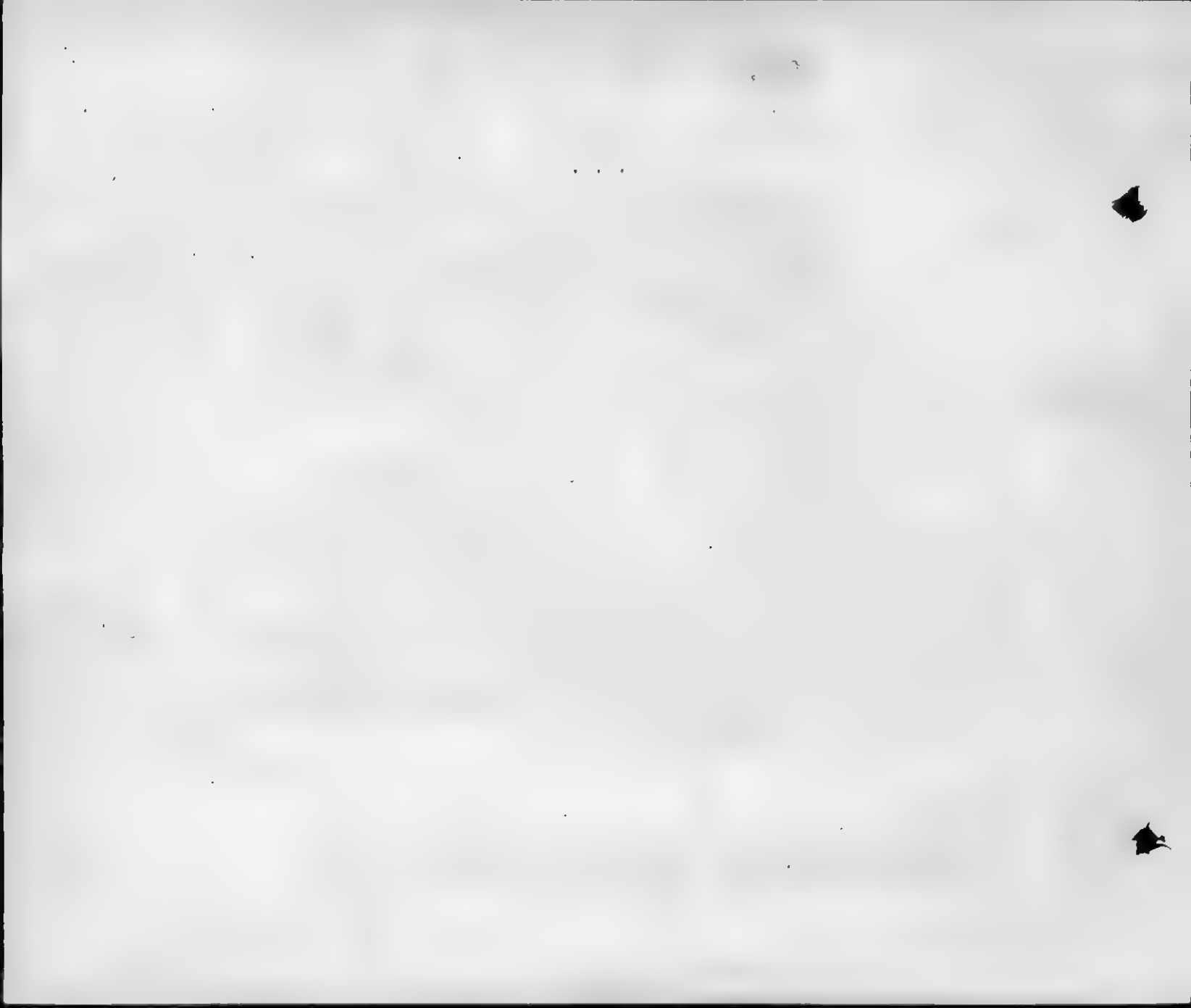
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1074											
1. PLACE OF DEATH											
a. COUNTY Prince George's											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly											
c. LENGTH OF STAY IN b. D.O.A. Hillside											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital											
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)											
a. STATE Maryland b. COUNTY Prince George's											
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hillside											
d. STREET ADDRESS 5704 Marlboro Pike											
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last											
Bayless A. SMITH											
4. DATE OF DEATH January 18 1961											
5. SEX Male											
6. COLOR OR RACE White											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH APRIL 17, 1902											
9. AGE (In years last birthday) 58 yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARTENDER											
10b. KIND OF BUSINESS OR INDUSTRY											
11. BIRTHPLACE (State or foreign country) INDIANNA											
12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME JAMES SMITH											
14. MOTHER'S MAIDEN NAME ZIE BENFIELD											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No											
16. SOCIAL SECURITY NO. 577-18-5822											
17. INFORMANT COYNER K. SMITH											
Address FRANKFORT, INDIANNA											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT											
420.1 DUE TO (b) CORONARY ARTERIOSCLEROSIS											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) and HYPERTROPHIC HEART											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute hemorrhagic PANCREATITIS and BRONCHIAL PNEUMONIA											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED 1/18/1961											
ACTUAL SIGNATURE James I. Boyd M.D.											
EXAMINER'S NAME (Type) James I. Boyd											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
22b. DATE THEREOF 1-21-1961											
22c. NAME OF CEMETERY OR CREMATORY Greenlawn											
22d. LOCATION (City, town, or county) (State) Frankfort, Indiana											
23. FUNERAL DIRECTOR W.W. Chambers Co											
ADDRESS Riverdale, Md											
24a. REC'D BY REGISTRAR											
24b. REGISTRAR'S SIGNATURE											
DATE JAN 25 '61											

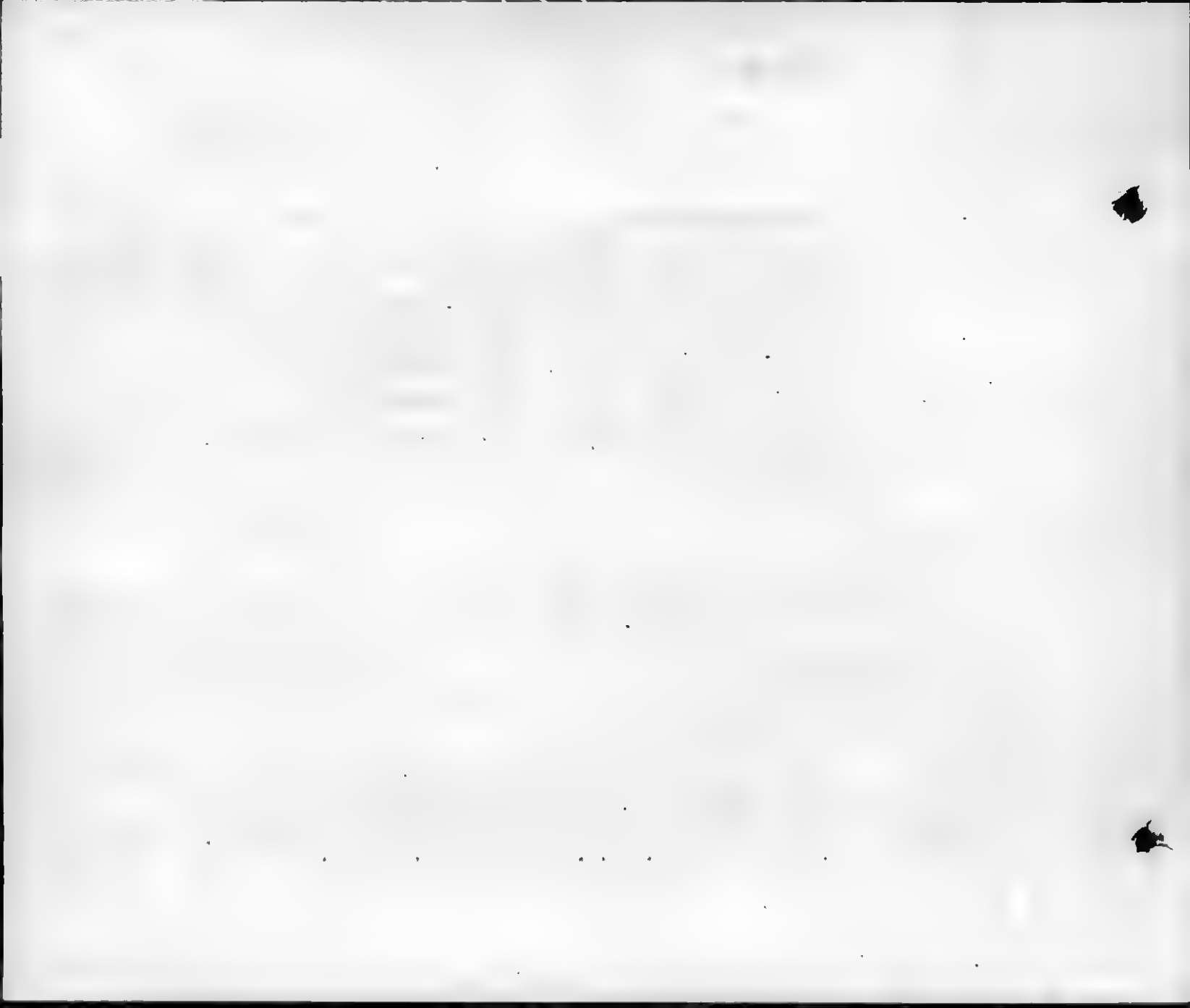


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1075

(1004)

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly				c. LENGTH OF STAY IN 1b 29 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges General Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47 Mt. Rainier			
f. STREET ADDRESS 3812 32nd Street				• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) Roy Smith			4 DATE OF DEATH Jan 11 19 61				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 11 June 1897		9. AGE (in years last birthday) 63 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Triangle Motors		11. BIRTHPLACE (State or foreign country) San Antonio, Texas		12. CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Ellery Smith			14. MOTHER'S MAIDEN NAME Frances				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 577-07-0376		17 INFORMANT Mary Forbes Smith, Wife Address above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute pul. edema 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic carcinoma DUE TO (c) metastases to the liver							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from June 57 to 1/11 , 1961, that (I) (we) lost the deceased alive on 1/11 , 1961, and that death occurred at 1,30AM from the causes and on the date stated above.							
22a. SIGNATURE Norman Comeau M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED 1/11/61	
22c. PHYSICIAN'S NAME (Type) Dr. Norman Comeau, M.D.				22d. ADDRESS 3503 Perry St. Mt. Rainier, Md.			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 14/61		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Columbia, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Valley's Funeral Home, Inc.				ADDRESS Mt. Rainier, Md.		25a. REC'D BY REGISTRAR DATE JAN 16 '61	
				25b. REGISTRAR'S SIGNATURE William S. Hines			



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1076 **CERTIFICATE OF DEATH** (1966)

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>		c. LENGTH OF STAY IN 1b <u>28 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverdale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6621 Auburn Ave</u>				e. STREET ADDRESS <u>6621 Auburn Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Lucille Snoddy</u> Middle Last				4. DATE OF DEATH <u>Jan 5 1961</u> Month Day Year			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 14, 1888</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>		11. BIRTHPLACE (State or foreign country) <u>Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Lawson</u>				14. MOTHER'S MAIDEN NAME <u>Legera Burnett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>John W Snoddy Same.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute Coronary Thrombosis - Sudden.</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease 10 years</u>							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>1940</u> to <u>Jan 5 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 3 1961</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>L W Malin</u> M.D.				22b. DATE SIGNED <u>1-5-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>L W Malin M.D.</u>				22d. ADDRESS <u>Riverdale, Md</u>			
23a. BURIAL, CREMATION, REMOVAL Specified <u>Burial</u>		23b. DATE THEREOF <u>1-8-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Newport Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Newport, Tennessee</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. CHAMBERS CO.,</u> ADDRESS <u>Riverdale, Maryland.</u>				25a. REC'D BY REGISTRAR <u>C. L. & H. H. H.</u>		25b. REGISTRAR'S SIGNATURE	
DATE <u>JAN 9 '61</u>							



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY <u>Prince George's</u> MARYLAND				a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
<u>Forestville</u>		<u>12 years</u>		<u>Forestville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
<u>3601-80th Avenue</u>				<u>3601-80th Avenue</u>			
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
<u>Garland Lucille Stafford</u>				<u>January 21 1961</u>			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
<u>Male</u>		<u>White</u>		<u>WIDOWED</u> <input type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>		<u>Nov 30, 1919</u>	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
<u>41 yrs.</u>		<u>Months</u> <u>Days</u>		<u>Hours</u> <u>Min.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Meat Cutter</u>				<u>Giant Foods</u>		<u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME			
<u>U. S. A.</u>				<u>Julius Stafford</u>			
14. MOTHER'S MAIDEN NAME				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
<u>Mary Hagenbach</u>				<u>Yes</u> <u>WWII</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT			
<u>237-01-8566</u>				<u>Nelen Stafford, same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)				<u>Coronary Occlusion</u>			
420.1 DUE TO				<u>Cardiovascular renal disease</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) DUE TO			
				(c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<u>Obesity</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
19							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James I. Boyd</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JAMES I. BOYD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>1-21-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>25 Jan. 1961</u>		<u>Arl. Nat. Cem.</u>	
						22d. LOCATION (City, town, or country) (State)	
						<u>Arl. Va.</u>	
23. FUNERAL DIRECTOR				ADDRESS		24a. REC'D BY REGISTRAR	
<u>Lee Funeral Home</u>				<u>300-4th St. N.E.</u>		DATE <u>JAN 24 '61</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	



1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

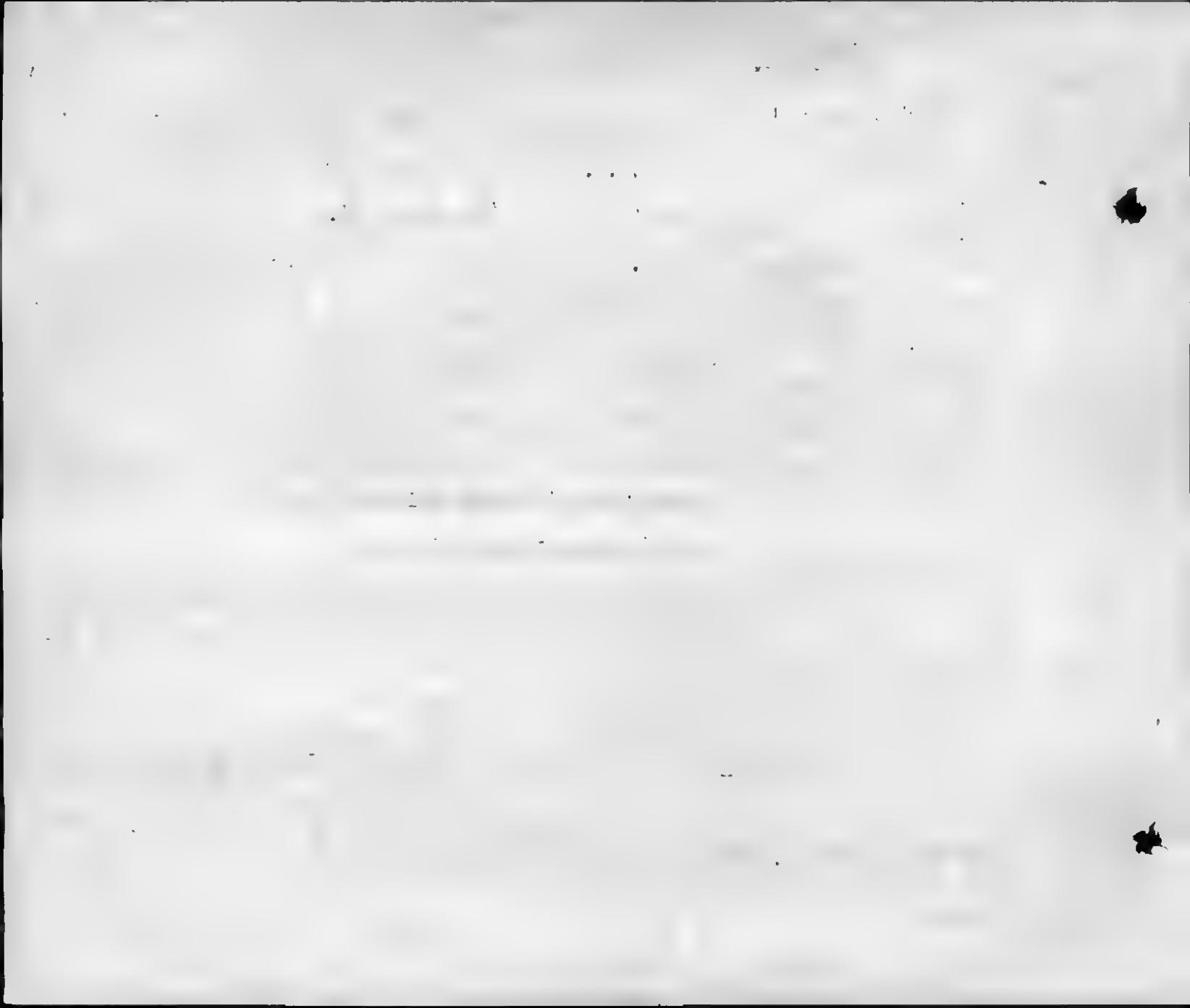
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1078 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(1067)

1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Prince George's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park d. STREET ADDRESS 4808 Erskin St.			
3. NAME OF DECEASED (Type or print) Nellie B. STEWART		4. DATE OF DEATH Month Jan Day 1 Year 1961		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 6, 1906		9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Beckley W. Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Lanner Carlisle		14. MOTHER'S MARDEN NAME Bertha Dillon		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Bertha Carlisle, Prince, W. Virginia		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiovascular renal disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE James I. Boyd		M.D. James I. Boyd		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1/1/61	
EXAMINER'S NAME (Type) James I. Boyd		Address (Street, city, town, or county)		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-5-1961	
22c. NAME OF CEMETERY OR CREMATORY Mt Olivet		22d. LOCATION (City, town or country) (State) Washington, D. C.		23. FUNERAL DIRECTOR W.W. Chambers Co		24. REC'D BY REGISTRAR Arthur S. Hanks	
24a. DATE JAN 5 '61		24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1079

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1003

1 PLACE OF DEATH a. <u>Prince George's</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
c. LENGTH OF STAY IN TB <u>4 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Pr. Geo. Gen. Hosp.</u>		e. STREET ADDRESS <u>386 Ardmore Rd.</u>	
3 NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>D</u> Last <u>Stumpf</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>23</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>26 Nov. 1877</u>
9. AGE (In years last birthday) <u>83 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Houses</u>	
11 BIRTHPLACE (State or foreign country) <u>Pa.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John C. Stumpf</u>		14. MOTHER'S MAIDEN NAME <u>Jane Riley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579098235</u>	
17 INFORMANT <u>Alice M. Stumpf</u>		Address <u>Same as # 2 (Wife)</u>	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>433.0</u> DUE TO <u>Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO <u>Pt. Bundle Branch Block</u> DUE TO <u>Generalized Arterio-Sclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>49 - 10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1956</u> to <u>Jan. 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 19 1961</u> , and that death occurred <u>2.55 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas M. Hutchinson</u>		22b. DATE SIGNED <u>23 Jan 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. T. Hutchins, M.D.</u>		22d. ADDRESS <u>7315 Landover Rd. Landover, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>1/25/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Pittsburg Pa.</u>
24 FUNERAL DIRECTOR'S SIGNATURE <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 24 '61</u>	
ADDRESS <u>Hyattsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Smith</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1080

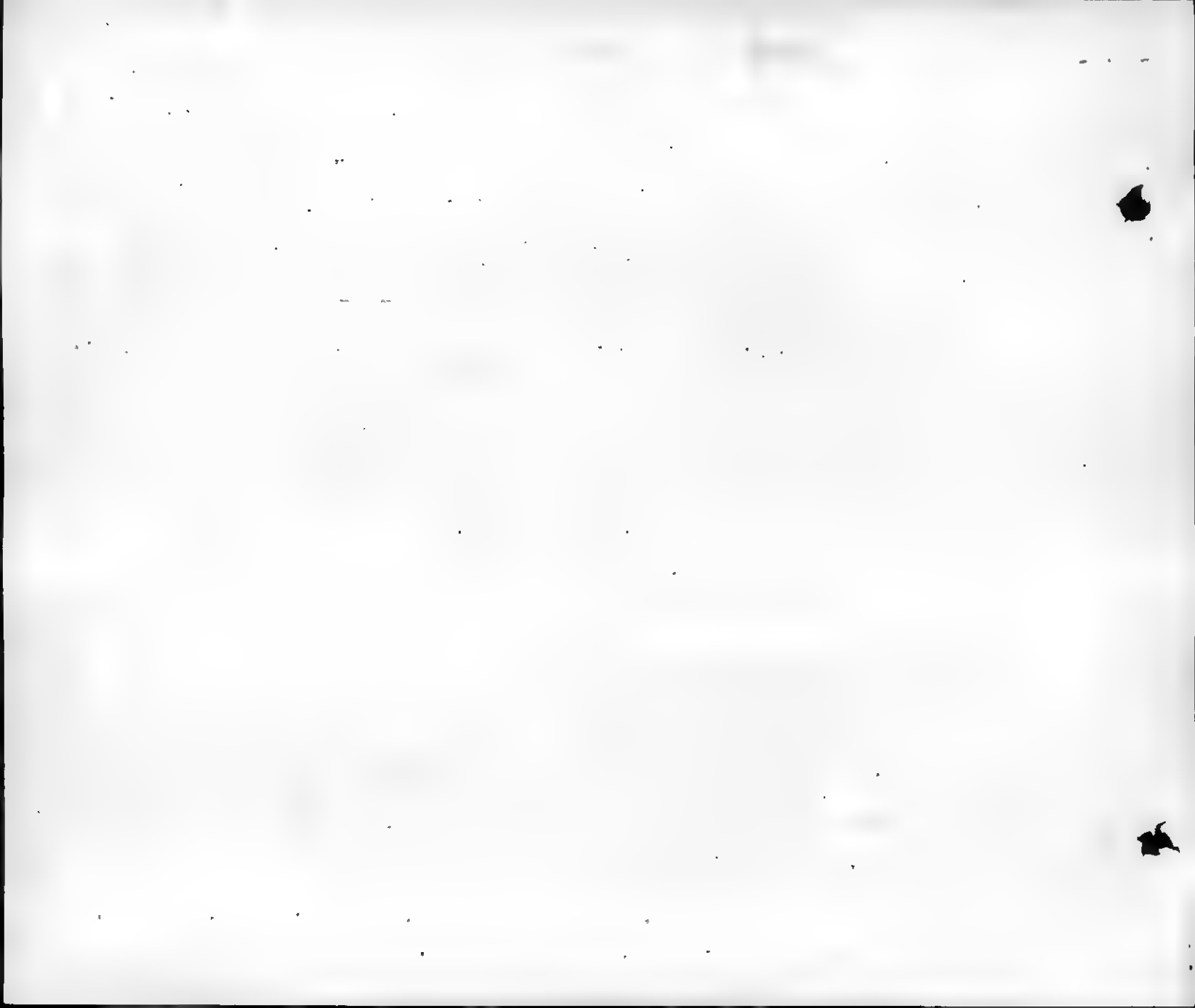
CERTIFICATE OF DEATH

Reg. Dist. No.

102283

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLINTON		c. LENGTH OF STAY IN lb 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SOUTHERN MARYLAND Hosp CENTER		e. STREET ADDRESS Box 286	
3. NAME OF DECEASED (Type or print) First John Middle Sylvester Last Tayman		4. DATE OF DEATH Month January Day 22 Year 1961	
5. SEX male	6. COLOR OR RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 17 1878
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 5 Days 10 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Tobacco)		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Brandywine Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM TAYMAN		14. MOTHER'S MAIDEN NAME Jenkins, Alice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. never had	
17. INFORMANT Francis Reinhardt		Address 1610 25th Pl SE	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio-renal disease (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 17 , 1961, to Jan 22 , 1961, that I last saw the deceased alive on Jan 22 , 1961, and that death occurred at 5:00 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE David N Rolfe		DATE SIGNED Jan 23/61	
PHYSICIAN'S NAME (Type) DAVID N ROLFE		ADDRESS (Street, city or town, state) Clinton Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/25/61	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cath Cem.	22d. LOCATION (City, town, or county) (State) Piscataway, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Ritchie Bros. Fun'l Home-Upper Marlboro, Md.		24a. REC'D BY REGISTRAR FEB 14 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



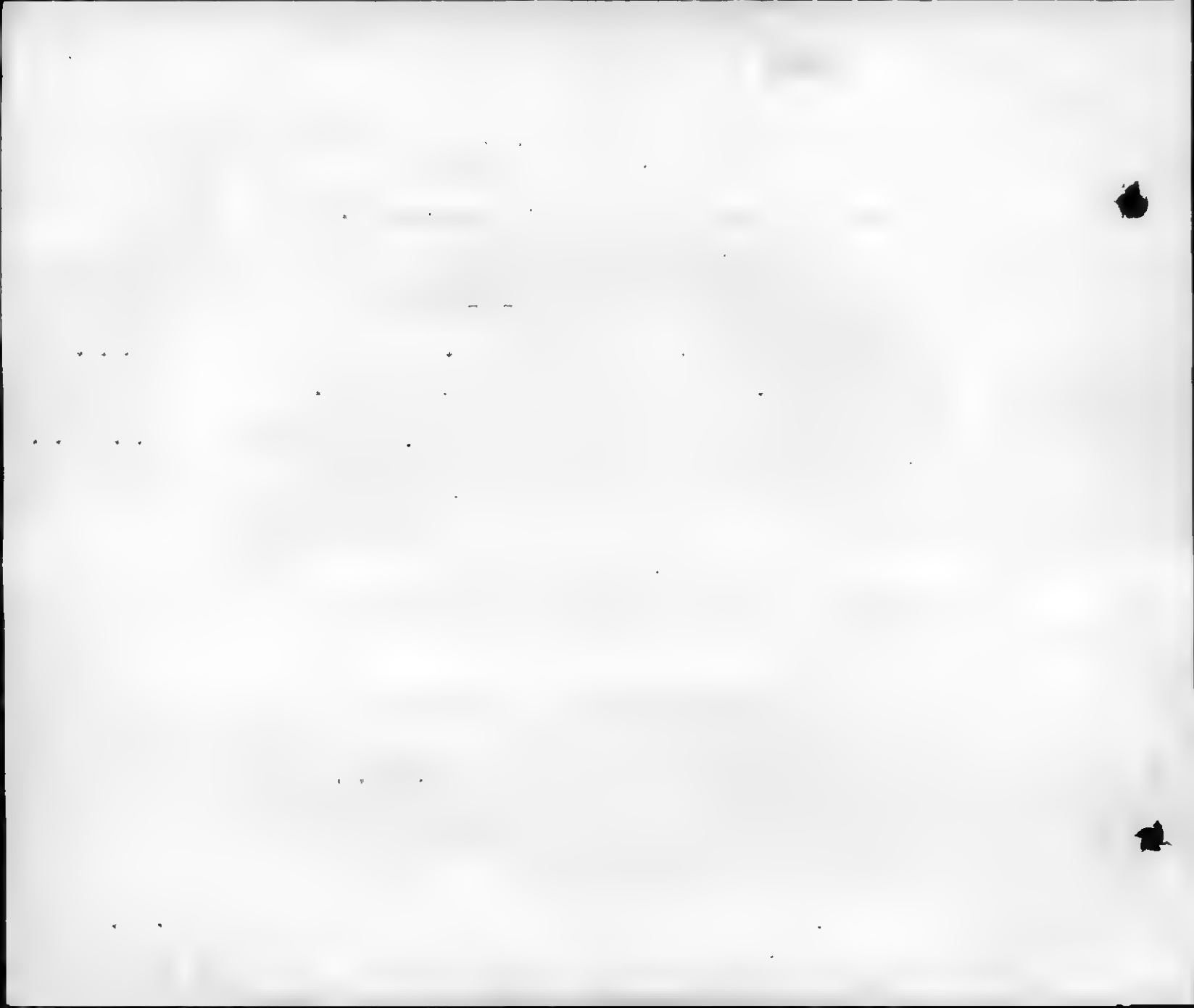
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1081

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1006

1. PLACE OF DEATH a. COUNTY Prince George		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George General Hospital		d. STREET ADDRESS 7611 Muncy Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mildred Thompson		4. DATE OF DEATH Month Day Year January 14 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-10-09
9. AGE (In years last birthday) 51 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD REYNOLDS.		14. MOTHER'S MAIDEN NAME MATTIE MOSS.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) #		16. SOCIAL SECURITY NO. #	
17. INFORMANT JAMES A. GREEN.		Address 718 RITTENHOUSE ST N.W. D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 171X DUE TO Broncho pneumonia (b) 1961 DUE TO Epidemic typhus (c) 1961 DUE TO Epidemic typhus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 13, 1961, to January 14, 1961, that (I) (we) last saw the deceased alive on January 14, 1961, and that death occurred at 8:45 p.m., the causes and on the date stated above			
22a. SIGNATURE John S. Haugh		22b. DATE SIGNED 1-15-61	
22c. PHYSICIAN'S NAME (Type) M.D.		22d. ADDRESS ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/17/61	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		23d. LOCATION (City, town, or county) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. R. Thompson		25a. REC'D BY REGISTRAR DATE JAN 17 '61	
ADDRESS 5732		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



may be returned by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

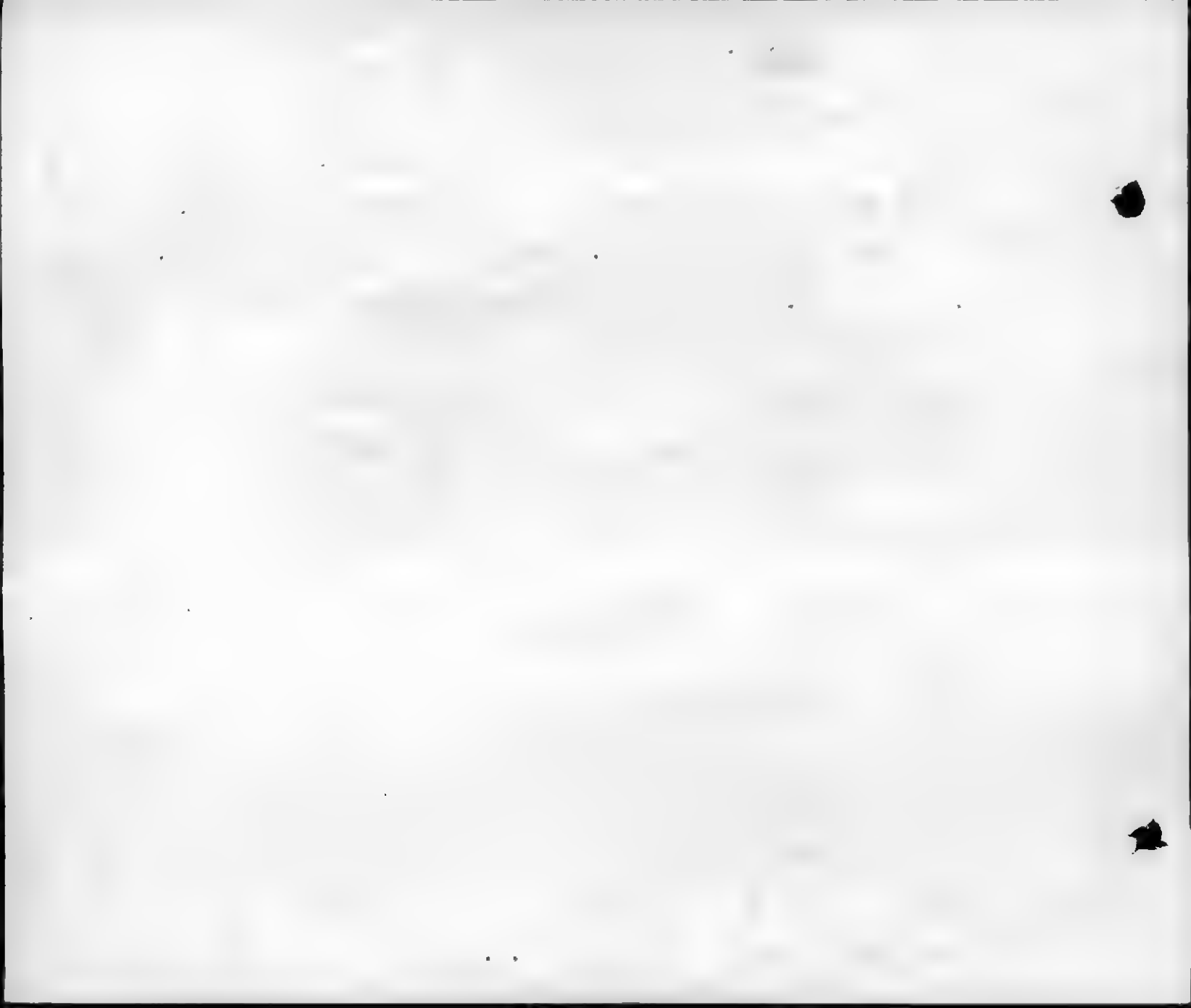
STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1082

CERTIFICATE OF DEATH

(1070)

1 PLACE OF DEATH a. COUNTY Pr George MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Avondale				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Carroll Manor Nursing Home				d. STREET ADDRESS 601- Girard Street N.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3 NAME OF DECEASED (Type or print) BERTHA First C. UMHAU Middle U Last				4. DATE OF DEATH January 2nd. 19 61 Month Day Year			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 6th. 1892	
9. AGE (In years lost birthday) 68 yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Buyer				10b. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME James P Critzer				14. MOTHER'S MAIDEN NAME Alice A Meeks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT Sister M Dennis		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 352X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1 year			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer - metastasizing							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21 I certify that (I) (this hospital) attended the deceased from 12/31 19 59 to 1/1 19 61 , that (I) (we) last saw the deceased alive on 1/1 19 61 , and that death occurred at 12 M, from the causes and on the date stated above.							
22a. SIGNATURE J. Chester Brady				22b. DATE SIGNED 1/2/61			
22c. PHYSICIAN'S NAME (Type) J. Chester Brady				22d. ADDRESS 35-244 Ave. N.W. Washington			
23a. BURIAL, CREMATION (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
Burial		1-4-61		Arlington National		Ft Myer Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington D.C.				25a. REC'D BY REGISTRAR JAN 5 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
1084 CERTIFICATE OF DEATH

(1072)

1. PLACE OF DEATH a. COUNTY <u>Prince George's, Md</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIVERDALE</u> c. LENGTH OF STAY IN 1b <u>1WK</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LELAND MEMORIAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria Va</u> d. STREET ADDRESS <u>1313 Powhatan St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Adam</u> Last <u>VINECK</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 24, 1910</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min. _____		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Worked @ Washington Hotel</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>WAITER</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Joseph Vineck Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Susan Hallek</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>144-05-9307</u>		17. INFORMANT <u>Mrs. Ruth Vineck</u>		Address <u>Garmers #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXIC CARDIAC FAILURE</u> DUE TO (b) <u>POST OPERATIVE DUODENAL LEAKAGE</u> DUE TO (c) <u>DUODENAL ULCER & PYLORIC OBSTRUCTION</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____				(County) _____		(State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>12-16</u> 19 <u>to</u> <u>1-2</u> 1961 that (I) (we) last saw the deceased alive on <u>1-3-1961</u> and that death occurred at <u>4:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Rowland Wilkinson</u>				22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>ROWLAND WILKINSON</u>				22d. ADDRESS <u>LELAND MEMO HOSPITAL, RIVERDALE, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JAN. 7, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART CEM.</u>		23d. LOCATION (City, town, or county) <u>DALLAS, PENNA.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co. Riverdale, Md.</u>				25a. REC'D BY REGISTRAR <u>JAN 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

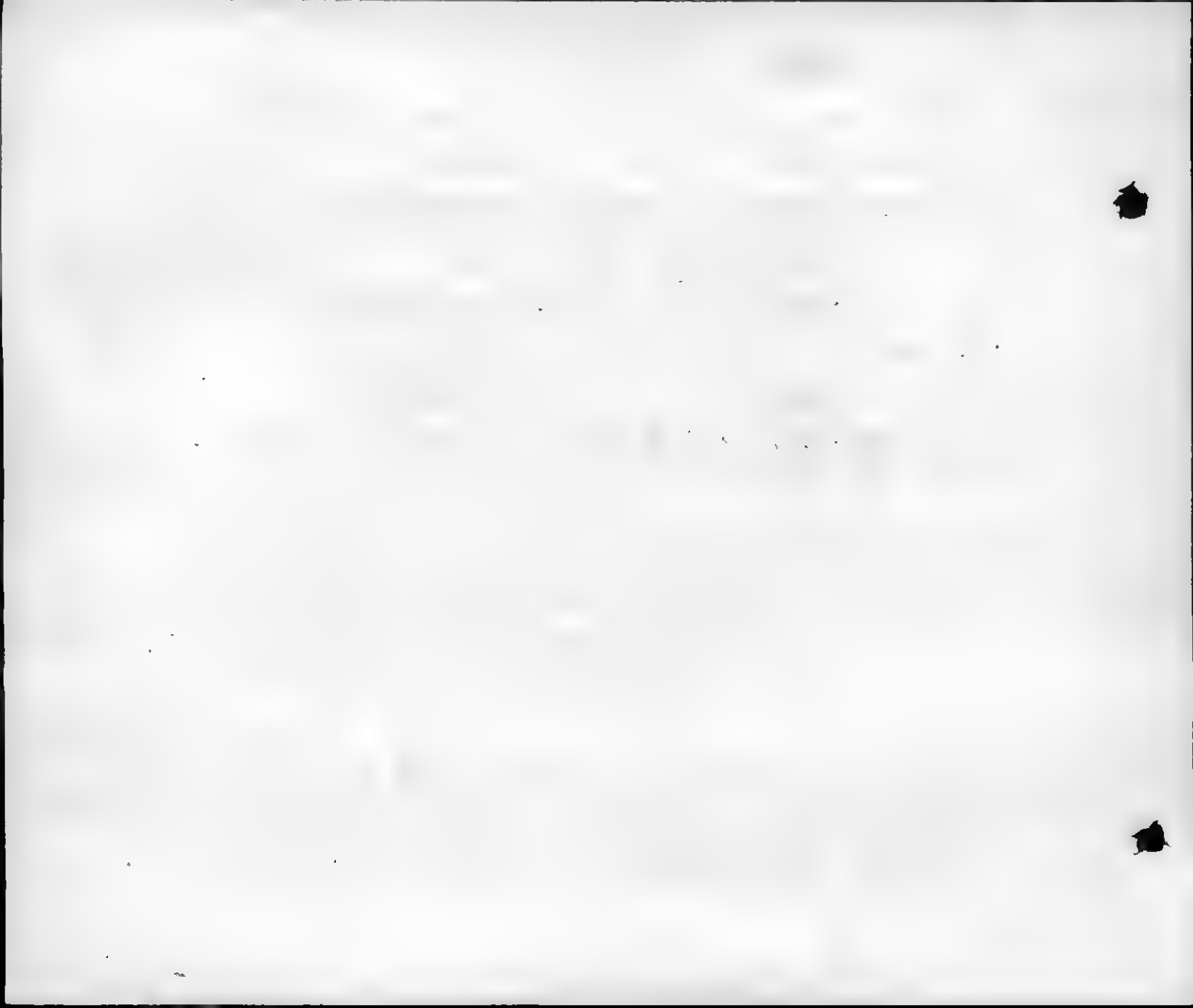
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1085

Item 14 Item 14 Item 14
CERTIFICATE OF DEATH

1073

1. PLACE OF DEATH a. COUNTY PRINCE GEORGES			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANDREWS AFB MARYLAND			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANNINGTON		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USAF HOSPITAL ANDREWS			e. STREET ADDRESS POST OFFICE BOX 241		
3. NAME OF DECEASED (Type or print) First Middle Last LOUIS J WASKO			4. DATE OF DEATH Month Day Year JANUARY 14 1961		
5. SEX MALE	6. COLOR OR RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 29 AUG 1919	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) US AIR FORCE		10b. KIND OF BUSINESS OR INDUSTRY USAF		11. BIRTHPLACE (State or foreign country) New Jersey	
13. FATHER'S NAME LOUIS WASKO			14. MOTHER'S MAIDEN NAME Unobtainable		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service)) YES 1941-1961			16. SOCIAL SECURITY NO 138-10-9837		
17. INFORMANT BETTIE WASKO (WIFE)			Address SAME AS #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 420.0 IMMEDIATE CAUSE (a) myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 mo			INTERVAL BETWEEN ONSET AND DEATH immediate		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a m p m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 14 JAN 1961		20g. (County) 14 JAN 1961		20h. (State) 14 JAN 1961	
21. I certify that (I) (this hospital) attended the deceased from 14 JAN 1961 to 14 JAN 1961 , that (I) (we) last saw the deceased alive on 14 JAN 1961 and that death occurred at 8:45 M, from the causes and on the date stated above.					
22a. SIGNATURE Albert D Carilli			22b. DATE SIGNED 14 JANUARY 1961		
22c. PHYSICIAN'S NAME (Type) ALBERT D CARILLI CAPTAIN USAF MC			22d. ADDRESS USAF HOSPITAL ANDREWS WASH 25, D.C.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 18 Jan. 1961		23c. NAME OF CEMETERY OR CREMATORY Fords N. J.	
23d. LOCATION (City, town, or county) Fords N. J.		23e. (State) Fords N. J.		23f. (State) Fords N. J.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert D Carilli			25a. REC'D BY REGISTRAR 816 N. H. D. E. Jr		
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			25c. DATE JAN 17 '61		





MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1075

CERTIFICATE OF DEATH

Items 11, 12, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN TB 40 Days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. Maryland b. COUNTY Prince George	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince George's General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Last Williams		4. DATE OF DEATH Month January Day 25 Year 1961			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/84	9. AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months 10 Days 19 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Prince Frederick, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ? Stewart		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (b) Anteroseptal Heart Disease (c) pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction (c) Myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Dec 16, 1960 to Jan 25, 1961 , that (I) (we) last saw the deceased alive on Jan 25, 1961 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Gordon W. Kelley		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. Gordon Kelley, M.D.		22d. ADDRESS 6124-41st Ave. Hyattsville, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-31-61		23c. NAME OF CEMETERY OR CREMATORY HARMONY	
23d. LOCATION (City, town, or county) (State) HIGHLAND PARK, MD.					
24. FUNERAL DIRECTOR'S SIGNATURE W. ERNEST JARVIS		ADDRESS 1432-YOU ST. N.W.		25a. REC'D BY REGISTRAR DATE JAN 30 '61	
25b. REGISTRAR'S SIGNATURE C. L. S. K...					



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

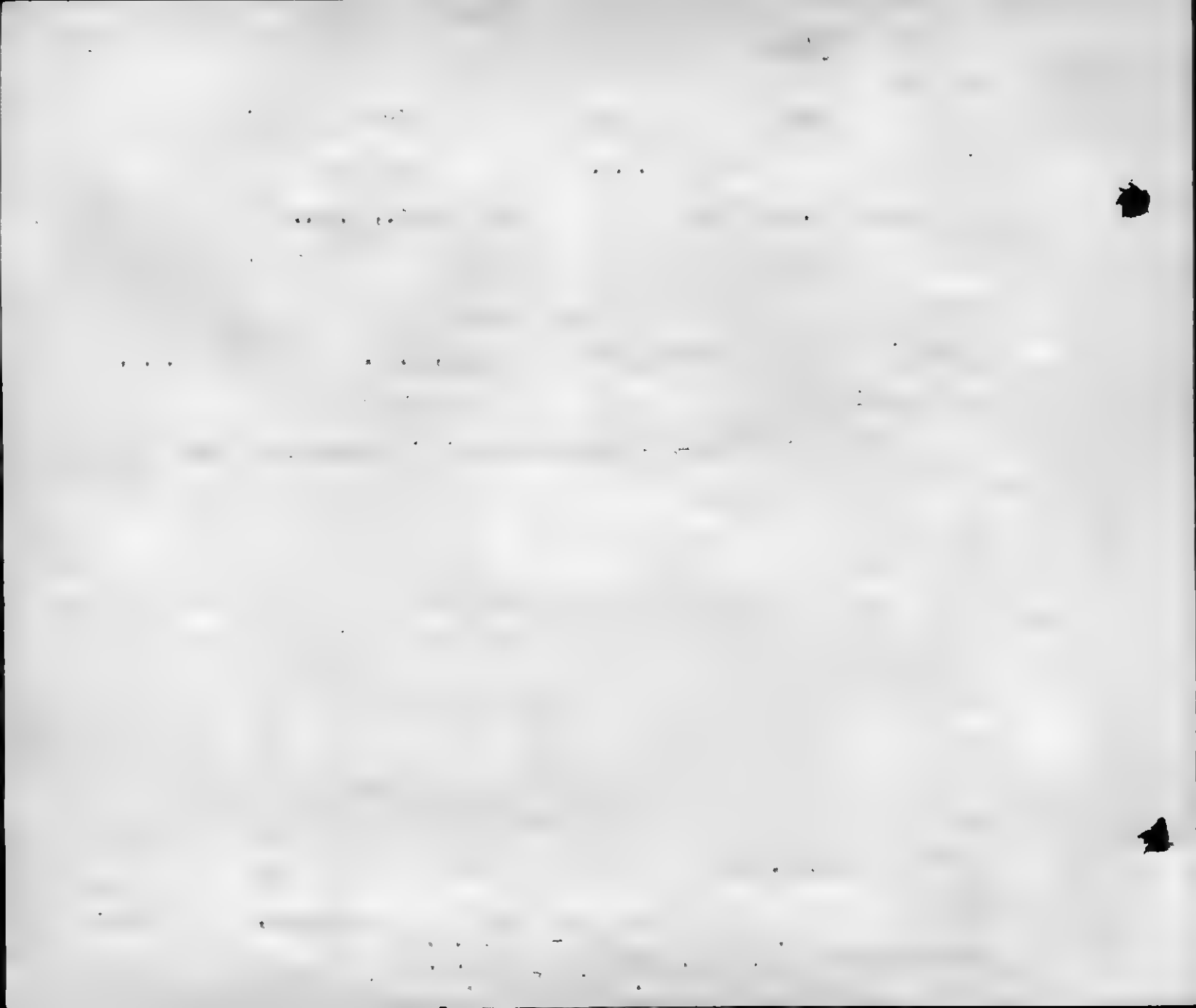
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1076

1. PLACE OF DEATH
a. COUNTY Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale
c. LENGTH OF STAY IN 1b MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eugene Leland Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institutional Residence before admission)
a. STATE District of Columbia
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. STREET ADDRESS 409 34th St., N. E.

3. NAME OF DECEASED (Type or print) Valier WILLIAMS
First Middle Last
4. DATE OF DEATH January 12 1961
Month Day Year
5. SEX Female
6. COLOR OR RACE Negro
7. MARRIED ☒ NEVER MARRIED ☐
8. DATE OF BIRTH 9/15/1918
WIDOWED ☐ DIVORCED ☐
9. AGE (In years last birthday) 42 yrs. **10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Domestic
11. BIRTHPLACE (State or foreign country) Salem, N. C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Eddie Gus Smith
14. MOTHER'S MAIDEN NAME Evelyn Watson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. 578-28-7425
17. INFORMANT Sampson Williams (Husband) same as # 2
Address _____
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Pulmonary edema
442X DUE TO (b) Congestive heart failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Cardiovascular renal disease
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes, Obesity, Arterio-sclerotic changes
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Jan 12 1961
Hour a.m. p.m.
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE James I. Boyd M.D.
EXAMINER'S NAME (Type) James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 1/12/61
Address (Street, city, town, or county)
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Jan. 17, 1961
22c. NAME OF CEMETERY OR CREMATORY Arlington National
22d. LOCATION (City, town, or country) (State) Arlington, Virginia
23. FUNERAL DIRECTOR John T. Rhine's Co. 3015-12th, N.E.
24. REC'D BY REGISTRAR JAN 17 '61
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
Remains released to John T. Rhine's Co. On Jan, 13th 1961



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1089

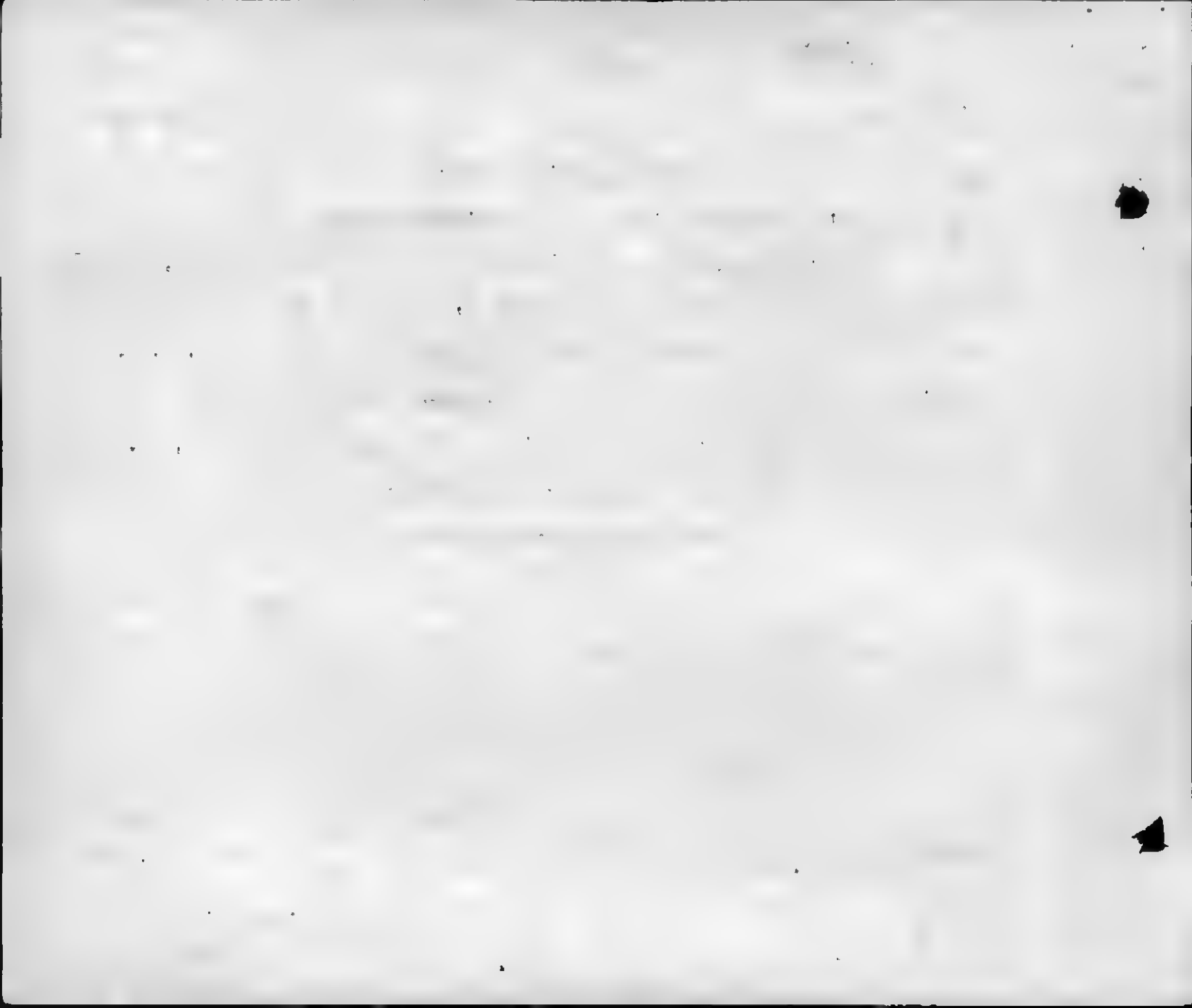
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02340

1. PLACE OF DEATH a. COUNTY Prince George b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b Dead on arrival d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prince George's General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Maryland b. COUNTY Prince George c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brightseat Road d. STREET ADDRESS Brightseat Road	
3. NAME OF DECEASED (Type or print) Edgar Cornelius Windsor		4. DATE OF DEATH January 15, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming Tenant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Wade Windsor		14. MOTHER'S MAIDEN NAME Unknown Blanche Kidwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) WW 11		16. SOCIAL SECURITY NO. 217-14-7008	
17. INFORMANT Elizabeth Garner, Seat Pleasant, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive Heart Failure DUE TO (b) Cardiovascular renal disease DUE TO (c) Cardiovascular renal disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 442 X	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James I. Boyd		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James I. Boyd		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/18/61	
22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or country) (State) Ft. Myer, Va.	
23. FUNERAL DIRECTOR Ritchie Bros. Fun'l Home-Upper Marlboro		24a. REC'D BY REGISTRAR FEB 14 '61	
ADDRESS Ritchie Bros. Fun'l Home-Upper Marlboro		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

2



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1090

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

6297

1 PLACE OF DEATH a. COUNTY Prince George's MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Pr. Geo's Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brandywine		c. LENGTH OF STAY IN 1b 3 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) Box. 4, Brandywine		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Brandywine, Maryland	
3. NAME OF DECEASED (Type or print) KATHLEEN First ANN MIDDLE Windsor Last		4. DATE OF DEATH Month Jan. 14th Day Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7- 1960
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Washington, DC		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME John E. Windsor		14 MOTHER'S MAIDEN NAME Pauline G. Willoughby	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT John E. Windsor		Address Same as # 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>James Beck & Ann M. Windsor</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>convulsions</u> DUE TO (c) <u>stroke</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-2 days</u> <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-11-1961 to 1-14-1961, that (I) (we) last saw the deceased alive on 1-14-1961, and that death occurred at 10 AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Dubson</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Richard H. Dubson		22d. ADDRESS Brandywine Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 16-61	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City, town, or county) (State) Piscataway, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Simmons Brothers</u>		25a. REC'D BY REG-STRAR DATE JAN 16 '61	
ADDRESS 1661- Good Hope Road SE Washington DC		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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61078
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH COUNTY Prince George General MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly		c. LENGTH OF STAY IN 1b 15 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Diane Middle Wright Last Wright		4. DATE OF DEATH Month 1/30/61 Day 1961 Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-99
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Washington D. C.
13. FATHER'S NAME Columbus O. Woodward		14. MOTHER'S MAIDEN NAME Laura V. Linthicum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Hospital records		Address Cheverly Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 29, 1961 to Jan 30, 1961 , that (I) (we) last saw the deceased alive on 1/30 1961 , and that death occurred at 9 AM , from the causes and on the date stated above.			
22a. SIGNATURE Hei K Lee		22b. DATE SIGNED Jan 30, 1961	
22c. PHYSICIAN'S NAME (Type) Hei K Lee		22d. ADDRESS Prince Georges Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/2/61	23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	23d. LOCATION (City, town, or county) Colmar Manor, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Francis Gasch's Sons		25a. REC'D BY REGISTRAR Hyattsville, Maryland DATE FEB 3 '61	
		25b. REGISTRAR'S SIGNATURE Arthur L. Frank	

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1092

CERTIFICATE OF DEATH

1079

1. PLACE OF DEATH a. COUNTY Pr George MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Suitland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Suitland Nurs ing Home				d. STREET ADDRESS 3139 Lyndale Pl S.E.			
3. NAME OF DECEASED (Type or print) First William Middle J. Zillhardt				4. DATE OF DEATH Month January Day 7 Year 1961			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1872	
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months 88 Days 88 Hours 88 Min. 88		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Christian Zillhardt				14. MOTHER'S MAIDEN NAME Dorthea Ziffle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Carolyn De Turk			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 11-25-60 to 1-7-61	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (the hospital) attended the deceased from 3-6-54 to 1-7-61 , that (I) (we) last saw the deceased alive on 1-2-61 , and that death occurred at M. from the causes and on the date stated above.			
22a. SIGNATURE Lawrence D. Summerfield				22b. DATE SIGNED 1-11-61			
22c. PHYSICIAN'S NAME (Type) LAWRENCE D. SUMMERFIELD, M.D.				22d. ADDRESS 1400 BRANCH AVE S.E. WASHINGTON 20 D.C.			
23a. BURIAL, CREMATION, or other disposition (Specify) Burial		23b. DATE THEREOF Jan. 10, 1961		23c. NAME OF CEMETERY OR CREMATORY Laureldale		23d. LOCATION (City, town, or county) (State) Redding, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home - Washington, D.C.				25a. REC'D BY REGISTRAR JAN 11 '61			
ADDRESS Lee Funeral Home - Washington, D.C.				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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